American Optometric Association
NEWS™

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Volume 50 March 2012 No. 9

President signs measure to avert massive Medicare pay cut

Facing increased pressure from the AOA and other physician organizations, U.S. House and Senate leaders came together last month to approve yet another measure to prevent enactment of a massive cut to Medicare payments made to optometrists and other physicians.

Part of a larger deal aimed at continuing a payroll tax break for workers and extending unemployment insurance for many jobless Americans, the compromise legislation was overwhelmingly approved in both houses of Congress shortly before the Presidents Day recess and then signed into law by President Obama.

Without the bipartisan action, Medicare physician reimbursement was scheduled to be cut by more than 27 percent starting March 1, 2012. As a result of this latest deal, under Medicare's sustainable growth rate for-

See Pay cut, page 6



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More than 700 ODs receive $18k EHR incentive bonuses

The Medicare Electronic Health Records (EHR) Incentive Program during 2011 issued payments to some 701 optometrists – all of whom received the maximum $18,000 incentive available during the first year of the program, according to the U.S. Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC).

That means optometrists have already received some $12.6 million in EHR incentives through the program, according to the CMS and ONC.

And that is probably just the beginning, AOA Advocacy Group Director Jon Hymes noted.

In all, some 1,238 optometrists actually attested compliance with Medicare EHR utilization criteria and qualified for incentive payments during 2011, according to the CMS and ONC.

However, over the first 12 months of the EHR program, the CMS issued incentive payments only to health care practitioners who were known to have reached a threshold of $24,000 in total Medicare allowable charges for the year, thereby qualifying for a maximum $18,000 EHR incentive.

Late last year, the CMS announced a two-month "grace period" (that ended Feb. 29) to give health care practitioners more time to report they met Medicare EHR program standards during 2011 as well as more time to file claims used in computing bonuses.

As a result, both the total number of optometrists qualifying for 2011 Medicare EHR incentives and the average amount of the payments they receive could increase notably, Hymes observed.

See Bonuses, page 20



President's Column
Will you help?

4

Optometric Economics
Eye care costs rose just 0.7% in 2011

7

Optometry loses one of its greatest: Dr. Irvin Borish

13

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CMS proposes Stage 2 EHR meaningful use criteria

The U.S. Centers for Medicare & Medicaid Services (CMS) would target interconnectivity among health care practitioners using electronic health records (EHRs) under Stage 2 Medicare EHR Incentive Program goals and objectives proposed by the agency last month.

The proposed Stage 2 objectives would be essentially the same as the Stage 1 objectives implemented last year, with two notable changes, according to a CMS fact sheet.

"(The) CMS proposes to maintain the same core and menu structure for the (EHR Incentive) program for Stage 2. We propose for Stage 2 that EPs (eligible providers) must meet or qualify for an exclusion to 17 core objectives and 3 of 5 menu objectives," the fact sheet states.

Nearly all of the CMS' Stage 1 core and menu EHR utilization objectives have been retained in the proposed Stage 2 objectives, the agency notes.

The CMS will change the "exchange of key clinical information" core objective established for Stage 1 to a "transitions of care" core objective – which the CMS considers "more robust" – in Stage 2, according to the fact sheet.

The agency will eliminate the Stage 1 "provide patients with an electronic copy of their health information" objective and replace it with an "electronic/online access" core objective in Stage 2, according to the agency.

"There are also multiple Stage 1 objectives that have been combined into more unified Stage 2 objectives, with a subsequent rise in the measure threshold that providers must achieve for each objective that has been retained from Stage 1. This eliminates an unnecessary accounting and reporting burden for providers by recognizing that, for providers who have been Stage 1 meaningful users for multiple years, recording these data in structured form has become a normal part of care delivery," the CMS fact sheet explained.

To qualify for incentive payments under the Medicare EHR Incentive Program, health care practitioners must implement EHR systems certified for use under the program and then meet utilization goals and objectives known as the "meaningful use" standards.

Practitioners can earn incentives for up five years over the six-year (2011-2015) life of the program. Practitioners can earn a first round of incentives by meeting the program's Stage 1 initial objectives during their first year of participation in the program and can then receive additional payments by meeting more advanced Stage 2 and Stage 3 objectives during subsequent years.

Nearly all of the CMS' Stage 1 core and menu EHR utilization objectives have been retained in the proposed Stage 2 objectives.

The Stage 2 objectives proposed last month are consistent with plans previously announced by the CMS to emphasize installation of EHR systems under Stage 1 of the program, interconnectivity among health care practitioners under Stage 2, and the use of EHRs to enhance patient care under Stage 3.

"Because the Stage 2 objectives will essentially be based on the Stage 1 objectives, it is important for practitioners who have met Stage 1 standards to maintain ongoing compliance," said Philip Gross, O.D., chair of the AOA Health Information Technology (HIT) Subcommittee. "That effectively gives practitioners a head start in maintaining the year-long compliance that is necessary to qualify for incentives under Stage 2 of the program." (See related article on page 5).

The Stage 2 meaningful use standards, officially proposed by the CMS in the *Federal Register*, are subject to a 60-day comment period.

The agency could issue a finalized version of Stage 2 rules as quickly as 90 days thereafter, according to the AOA Advocacy Group.

The AOA Advocacy Group holds any use of EHRs that improves patient care could be considered "meaningful" and has been encouraging the CMS to ease specific utilization criteria as a means of reducing administrative burdens on practitioners and thereby encouraging EHR use.

"The AOA encourages members to implement EHRs, but not everyone can be an advanced user right away," an AOA Advocacy Group staff person noted.

The finalized Stage 2 EHR standards will be the subject of a detailed analysis in a future edition of *AOA News*.

The Stage 2 standards will also be covered in the AOA's "Navigating Meaningful Use, Quality Reporting, and e-Prescribing with Electronic Health Records (EHR)" continuing education courses, according the AOA HIT Subcommittee (see related article on page 19).

AOA members can find a direct link to the proposed Stage 2 standards as well as other information on the Medicare EHR Incentive Program on the AOA website EHR page (*www.aoa.org/EHR*).

New ways to connect with AOA...

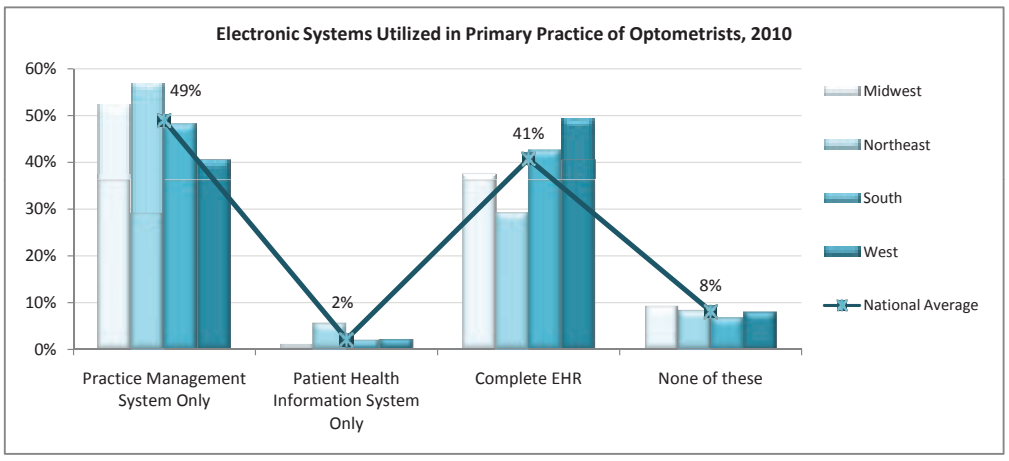
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OPTOMETRY FACTS IN FOCUS

According to the 2011 New Technology & EHR Survey, 41% of optometrists were using a complete EHR system in their primary practice in 2010. More than half of optometrists (59%) had not implemented a complete EHR system, and the majority of these optometrists (49%) continued to utilize a practice management system only. 48% of optometrists who were not using a complete EHR system in 2010 said they planned to acquire a complete EHR system during 2011. Watch for the results of the 2012 New Technology & EHR Survey in May of this year to see how many optometrists implemented a complete EHR system in 2011.



Source: AOA Research & Information Center, 2011 New Technology & EHR Survey.

Visit www.aoa.org/2011NewTechSurvey to read the executive summary and learn how you can obtain detailed results from the 2011 New Technology & EHR Survey.

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Will you help?

I've had the opportunity to visit most of the schools and colleges of optometry at this point. Invariably, I get asked: "How did you first get involved in the AOA?" I wouldn't have considered myself a political person. However I ran into some issues when my husband Mark and I opened our first practice. Someone told me I couldn't do something BECAUSE I was an optometrist. Then insurance companies wouldn't reimburse us for services we were skilled to do BECAUSE we were optometrists. I was raised to believe that it does no good to complain. If something isn't right, change it. So I asked my state association how I could help, and the rest is history.

Over the years, optometry has been on the harmful end of all sorts of discrimination. From being denied access to medical panels for some of the nation's largest health insurance plans, to fighting organized medicine and their allies for the right to practice and provide care for our patients as doctors, our profession has always faced both overt and covert discrimination. Many of you know what I'm talking about—issues such as ODs paid less for the same services as other professions, ODs not reimbursed because they are not an MD or restricting ODs to only vision panel participation and not allowing us access to the medical panel. And, while we've made great strides over the years in the fight to end this blatant discrimination, the core of the AOA's advocacy efforts necessarily remains focused on fighting against any type of discrimination against our profession.

That's why as the debate over health care reform intensified and a number of proposals posed a new discriminatory threat, the AOA sought to build support in Congress for the strongest possible patient access safeguards we could enact into law. It was an effort by more than just AOA leaders. It included AOA Federal Keypersons who traveled to the U.S. Capitol every year during the annual Congressional Advocacy Conference. It included the ODs who met with their U.S. House members and senators back home. It was the ODs and students who invested in AOA-PAC and the concerned AOA doctors (and patients) from across the country who got involved and wrote, faxed, emailed or called Congress whenever they were asked to do so by our Washington office. Were you one of those doctors who helped?

As the initial proposal became actual legislative language, the AOA threw its full support behind the Harkin Amendment— through committee-level consideration, Senate debate and final passage in both houses of Congress. A historic victory for the profession, the new law is now the first-ever federal standard of provider non-discrimination, marking a new era and a more level playing field in how health plans treat optometrists and our patients. The AOA had to overcome intense opposition from powerful special interests to get this key provision included in the final version of health reform legislation. Were you one of those doctors who helped?

I was raised to believe that it does no good to complain. If something isn't right, change it.

Some are now saying it wasn't enough. They also suggest the AOA should have gotten more. Of course, if it was up to the AOA to write much of the nearly 2,000 pages of the health overhaul legislation ourselves, some of the new law's provisions would have been drafted differently. But, the legislative process at the national level is highly competitive, and insurers and organized medicine opposed us at every step of the process. No one can deny the Harkin Amendment will expand patient access to optometric care and that the AOA – and the AOA alone – was at the table fighting for our members. Were you one of those doctors who helped?

Did you know the American Medical Association singled out the Harkin Amendment as one of the provisions of the 2010 health care overhaul law medical groups most want to repeal? In fact, they have called to "immediately condemn and work to repeal new Public Health Service Act Section 2706, the so-called provider 'Non-Discrimination in Health Care Act.'" And organized medicine isn't alone. The health insurance industry is just as active in trying to repeal the Harkin patient access protections. The insurance industry is avoiding these same type of public announcements, but we know they've hired an army of lobbyists and have their sights set on limiting patient access to their local doctors of optometry.

For the AOA, leading the fight against any and all types of discrimination against our members will continue be one of our highest priorities. But fighting back against the discriminatory efforts of health plans and organized medicine takes time, energy and resources. So I ask you: will you help?



Dr. Carlson

See President, page 13

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Stage 2 EHR incentives require year-long meaningful use

Health care practitioners who successfully attested compliance with Medicare standards for the "meaningful use" (MU) of electronic health records (EHR) last year, and thereby qualified for bonuses under the 2011 Medicare Electronic Health Records Incentive program, will have to meet Medicare EHR utilization criteria all year long if they want to qualify for incentives again in 2012, according to the AOA Health Information Technology (HIT) Subcommittee.

"While practitioners in their first year of participation need only maintain compliance with specified EHR utilization criteria for 90 consecutive days over the course of a calendar year to qualify for the Stage 1 Medicare EHR incentives that were available in 2011, they must meet specified utilization criteria continuously for 12 months to qualify for incentives during their second year of participation," said Dr. Gross.

Practitioners can earn up to $18,000 for meeting Stage 1 EHR use requirements during their first year in the Medicare incentive program, up to $12,000 for meeting requirements during a second year in the program, and as much as $8,000 for meeting requirements during subsequent years in the incentive program.

The U.S. Centers for Medicare & Medicaid Services (CMS) recently proposed standards for Stage 2 meaningful use (see related article on page 3).

The Medicare EHR Incentive Program runs from 2011 to 2015.

Health care practitioners can qualify for incentives for up to five consecutive years.

Practitioners who fail to meet EHR utilization requirements by 2015 will be subject to Medicare fee reductions.

"Optometrists who met Medicare meaningful use EHR standards during the first year of the incentive program should continue to meaningfully use EHRs for all patients so they do not fall behind on compliance during years two through five of the program," Dr. Gross said.

"Beyond that, optimum use of electronic health records is important in ensuring patients get appropriate care," Dr. Gross said.

"It is also an important way to prepare a practice for emerging coordinated care models and new pay-for-performance reimbursement systems that will rely on data generated by EHRs," Dr. Gross added.

For additional information, see the AOA Web site EHR page (*www.aoa.org/ehr*).



Pay cut,

from page 1

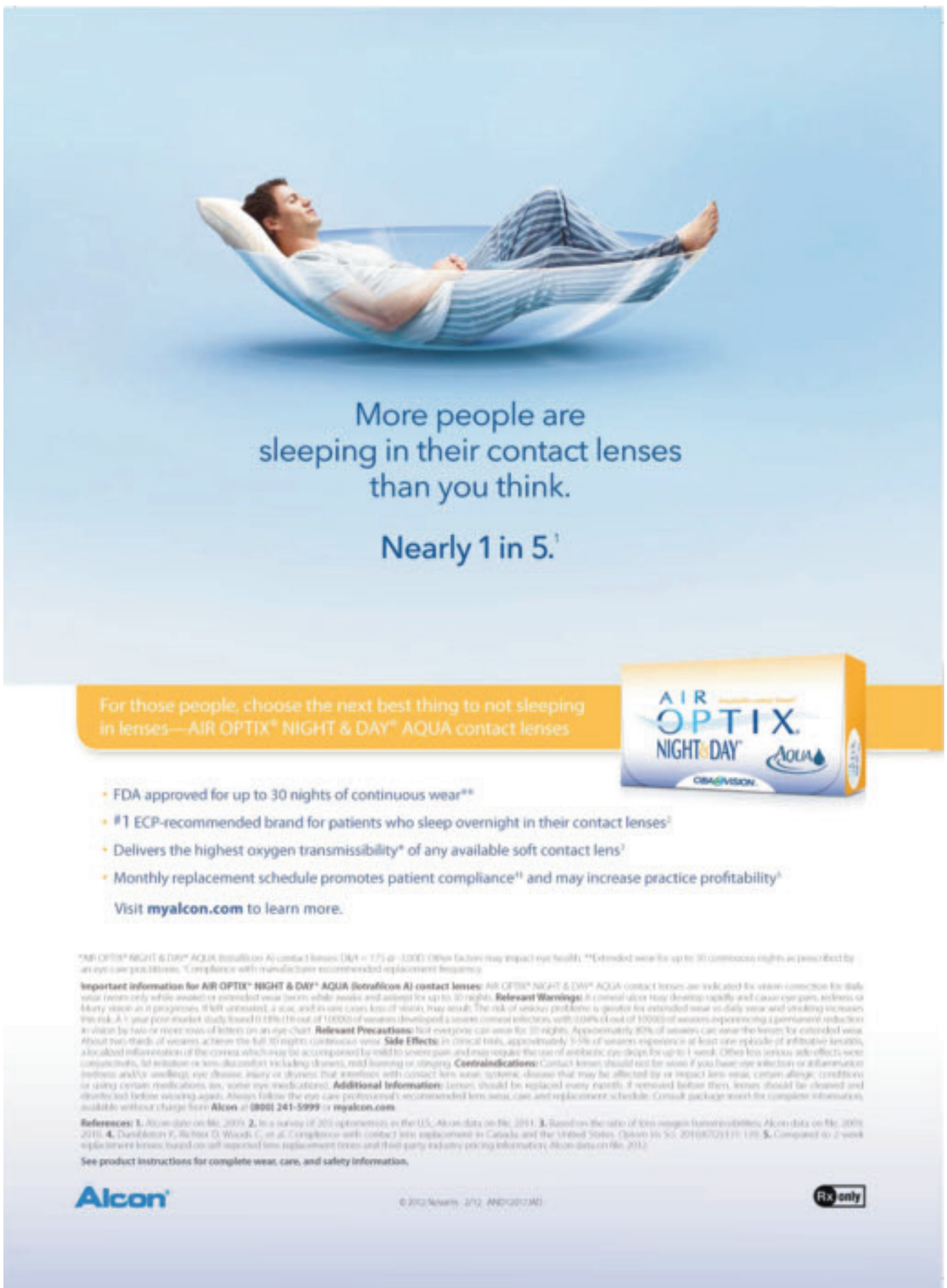
mula (SGR), a roughly 32 percent cut is now scheduled to take effect Jan. 1, 2013.

While not fully financed, some of the legislation's price tag was paid for by requiring new federal workers to contribute at a higher rate to the federal retirement program.

The compromise plan also called for a $5 billion reduction in the Affordable Care Act's $15 billion prevention and public health fund.

While the reductions mandated as a result of the SGR formula would alone be disastrous for ODs and other physicians, these scheduled cuts could be in addition to further reductions stemming from the debt ceiling compromise approved before the end of last year.

Officially known as the Budget Control Act, the plan called for $984 billion in cuts over 10 years in exchange for an increase in the amount of money the federal government may borrow to meet its obligations.



In 2013, the across-the-board cuts would roughly amount to $109 billion.

The overall sequester mechanism would mean Medicare physician payments would also be subject to the automatic reductions.

Initial estimates show the resulting cuts to doctors would equal about 2 percent per year, amounting to approximately $10 billion each year for 10 years.

While continuing the work to avert cuts as a result of the SGR, the AOA is increasingly focused on confronting the sequester threat.

Already, congressional leaders are beginning to focus on delaying sequestration by implementing a plan that would find savings elsewhere or repealing future cuts through an overall package large enough to achieve significant debt reduction.

However, now that the threat of immediate cuts has been successfully averted for 2012, optometrists are on track to see even higher Medicare payments for the remainder of 2012.

While most physicians will continue to receive 2011 payment rates through 2012, many ODs will see a roughly 2 percent increase in reimbursements in 2012, worth $20 million this year alone.

After meeting with AOA volunteers and staff, the Centers for Medicare & Medicaid Services (CMS) confirmed it would place a higher relative value on eye care services.

The OD increase comes as a direct result of the AOA's ongoing advocacy in the nation's capital and could mean that this year optometry will pass $1 billion in Medicare annual allowed charges for physician services.

Of the 56 specialties tracked by the CMS, only two will see a larger percent

see Pay cut, page 30

Eye care costs rose just 0.7% during 2011

The Eyeglasses and Eye Care Services Index, compiled by the U.S. Department of Labor's Bureau of Labor Statistics (BLS), increased a mere 0.7 percent during 2011. That was well under last year's overall inflation rate of 3 percent and a fraction of the 3.5 percent increase posted for health care costs overall during 2011, according to BLS Consumer Price Index (CPI) data.

Virtually every year since the government first began tracking them, increases in patient charges related to eye care have trailed both the overall inflation rate and increases in charges related to most other health care services.

Prices for eyewear and professional fees for eye care increased 0.3 percent in 2010.

The overall inflation rate was 1.5 percent that year.

(For Eyeglasses and Eye Care Services Indices by year, see Table 1 on page 24.)

In determining the nation's rate of health care cost inflation, the BLS tracks a variety of care-related charges, from hospital and nursing home services, to professional fees charged by health care practitioners, and the prices of health care products.

The Eyeglasses and Eye Care Services Index has traditionally risen more slowly than the BLS' other professional health services indices.

That is because, unlike other BLS professional health service indices, the Eyeglasses and Eye Care Services Index reflects both fees for professional services and the cost of related health care commodities (specifically eyeglasses and contact lenses).

Patient costs for eye care and eyewear last year increased less than costs for any almost other category of health care product or service.

Professional fees tend to rise faster than prices for health care-related commodities, according to the BLS.

In addition, eyewear, unlike many other health care commodities, is often placed "on sale" by retailers.

As a result, sale pricing is often reflected in the BLS Eyeglasses and Eye Care Services Index.

As in most years, eye care-related charges last year not only increased less than the fees charged for any other health care service but less than almost any other health care-related cost.

Eyeglasses and eye care services were trailed in the BLS health care inflation survey last year only by nonprescription pharmaceuticals, which increased a scant 0.1 percent, and medical equipment and supplies, which decreased in price 0.4 percent.

Other health costs

The 3.5 percent increase in the overall cost of health care in 2011 (up slightly from a 3.3 percent increase in 2010) reflected a 3.6 percent increase in medical care services (which rose 3.4 percent in 2010), a 3.2 percent increase in medical care commodities (up from a 2.9 percent increase in 2010), and a 6.1 percent increase in the cost of health insurance (which decreased 4 percent in 2010).

Like other Consumer Price Index data, the BLS medical care indices are limited to items with an out-of-pocket expenditure.

In the case of health insurance, out-of-pocket expenditures are defined to include the portions of health insurance premium amounts paid by consumers.

The 3.6 percent increase in medical care services last year came as a result of a 2.2 percent increase in professional services (which rose 2.7 percent in 2010) and a 5.3 percent increase in fees for hospital care and related serv-

See Index, page 10

CMS begins 5010 software enforcement at end of month

Health care practitioners have until March 31 to make sure their insurance claims are being filed using new ASC X12 Version 5010 billing software, according to the U.S. Centers for Medicare & Medicaid Services (CMS) Office of E-Health Standards and Services (OESS). Those who do not will find their claims rejected and face possible enforcement action, the agency said. (See related article on page 42.)

By now, most optometrists who file claims in-office using practice software have probably received 5010 updates from their software vendors, according to the AOA Clinical and Practice Advancement Group (AOA-CPAG). Practitioners who use outside billing services to file claims have also probably been notified by now that their services have 5010 software in place, AOA-CPAG noted.

Practitioners who have received such notices should now be conducting tests to ensure their claims will be filed and related transactions conducted smoothly in the new 5010 format, according to the CMS. Testing instructions should be provided in notices from software vendors and billing services, according AOA-CPAG.

Those who have not been notified should contact their software vendors or billing services to determine when 5010 updates will be completed, the agency said. For additional information, see the AOA website 5010 page (*www.aoa.org/5010*).





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References: 1. Based on a post-launch evaluation in which 88 eye care practitioners refit over 400 patients in AIR OPTIX® AQUA contact lenses. Alcon data on file, 2011. **2.** Nash W, Gabriel M, Mowrey-McKee M. A comparison of various silicone hydrogel lenses: lipid and protein deposition as a result of daily wear. Optom Vis Sci. 2010;87:E-abstract 105110. **3.** Compared to HEMA contact lenses; based on the ratio of lens oxygen transmissibilities; Alcon data on file, 2010. **4.** Dumbleton K, Richter D, Woods C, et al. Compliance with contact lens replacement in Canada and the United States. Optom Vis Sci. 2010;87(2):131-139. **5.** Compared to 2 week replacement lenses; based on self-reported lens replacement time and third-party industry pricing information; Alcon data on file, 2012.

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New course helps practices benefit under health care reform

The successful practice of optometry under emerging "value-oriented" payment systems will be the subject of a first-of-its-kind continuing education course offered this year at Optometry's Meeting®, according to the AOA Clinical and Practice Advancement Group (AOA-CPAG).

"Health Care Reform: A Clinical Approach on How to Adopt and Integrate Incentive Programs, Quality Reporting, and Coding Changes into Your Practice" will outline a method for improving patient care while enhancing practice revenues through participation in public- and private-sector quality improvement programs, according to course co-presenters Greg Caldwell, O.D., and Phil Gross, O.D.

"Primary care will be the central focus of the reformed health care system, and optometrists, as American's primary eye and vision care providers, are excellently positioned to play a key role," Dr. Gross noted. "However, the reformed system will also be centered around a transition from the traditional fee-for-service reimbursement system to new value-oriented, or outcomes-based, payment systems under which practitioner reimbursement will be based – not just on the volume of services provided – but on patient outcomes, meeting recognized care standards, and taking extra measures to ensure excellent care or to proactively prevent health problems."

"This will require a fundamental shift in the way health care practitioners think about day-to-day patient care and a new style of practice management," Dr. Caldwell said.

"This course will benefit AOA members no matter what the outcome of the Supreme Court challenge to the Accountable Care Act," Dr. Gross added.

The reformed health care system will involve a number of interrelated components including certification programs, quality reporting systems, advanced health information technology, new health care coding systems, and pay-for-performance programs, Drs. Caldwell and Gross noted.

"Optometrists must understand these components and how they will each help to enhance the quality of patient care as well as how each will be a factor in the reimbursement a practitioner receives," Dr. Gross said.

Examples of programs already in place include Medicare's

- Physician Quality Reporting System (PQRS)
- Electronic Health Records Incentive Program
- e-Prescribing Incentive Program, and
- Maintenance of Certification program

Through such programs, health care practitioners can already substantially enhance their income by earning bonuses totaling up to 2.5 percent of their total Medicare allowed charges for the year, or $18,000 plus 1.5 percent of their total Medicare allowed charges.

Under value-oriented reimbursement, such incentives will increasingly become a major part of the total reimbursement a practitioner receives, Drs. Caldwell and Gross noted.

Conversely, health care practitioners who fail to participate in such programs will increasingly be subject to financial penalties, they add.

Full participation in quality reporting and other incentive programs could become an important means of protecting practice revenues against potential across-the-board insurance plan pay cuts – such as the planned 27 percent Medicare fee reduction that was forestalled until the end of this year, according to the AOA Advocacy Group.

Eventually, participation in such programs will be strongly encouraged or required of practitioners on most health plan provider panels, the AOA Advocacy Group said.

Participation in emerging value-oriented reimbursement systems will require practitioners to become familiar with accepted clinical quality measures and the coding systems – such as the National Quality Forum codes – used to report them on claims.

Health care practitioners will also be required to master the new International Classification of Disease -10th Edition coding system that will be introduced to the U.S. health care system over the next decade to provide greater specificity in the reporting of diagnoses and treatment, the AOA Advocacy Group noted.

The new "Health Care Reform: A Clinical Approach" course will provide practical strategies for incorporating quality reporting and incentive programs into optometric practice.

The course will cover the integration of quality care measures into daily practice, the use of health information technology to facilitate care and participation in incentive program, and the proper reporting of incentive program participation on claims.

Case-by-case examples in patient care will be provided.

"Health Care Reform: A Clinical Approach on How to Adopt and Integrate Incentive Programs, Quality Reporting, and Coding Changes into Your Practice" will be offered at Optometry's Meeting®, Thursday, June 28, 10 a.m. to noon. Seating is limited.

Optometry's Meeting will be held June 27-July 1 in Chicago.

While Optometry's Meeting® is open to all optometrists, AOA members can register for the meeting and continuing education courses at discounted rates.

AOA members can register for the meeting and the course on the Optometry's Meeting® website (*www.optometrysmeeting.org*).

Medicare Advantage premiums down 7% on average, enrollment up 10%

Medicare Advantage premiums fell by 7 percent on average and enrollment rose by about 10 percent since this time last year, HHS Secretary Kathleen Sebelius announced last month.

The enrollment numbers confirm projections from last September that enrollment in Medicare Advantage plans would continue to rise and average premiums would continue to fall.

Average monthly premiums fell from $33.97 in 2011, to $31.54 in 2012, while enrollment has risen from 11.7 million in 2011 to 12.8 million in 2012.

"The Medicare Advantage program is stronger than ever," said Secretary Sebelius. "Premiums are down on average, enrollment is up, and thanks to the Affordable Care Act we have unprecedented new tools to ensure that seniors and people with disabilities are getting the best value out of their coverage."

In addition to today's enrollment and premium numbers, there is more evidence the Medicare Advantage program remains strong:

- On average, there are 26 Medicare Advantage plans to choose from in nearly every county across the country;
- Access to Medicare Advantage remains strong: 99.7 percent of Medicare beneficiaries have access to a Medicare Advantage plan; and
- Since 2010, when the Affordable Care Act was passed, Medicare Advantage premiums have fallen by 16 percent and enrollment has climbed by 17 percent.

"Not only are average premiums lower, but plans are better, with more beneficiaries enrolled in four and five-star plans," said CMS Acting Administrator Marilyn Tavenner. "The Affordable Care Act has strengthened Medicare Advantage by motivating plans to improve the quality of their coverage."

In 2012, as part of the Affordable Care Act, Medicare Advantage plans will start receiving incentives to achieve high quality scores through the use of quality bonus payments.

As an extra incentive for high-quality performance, the CMS is allowing Five-Star Medicare Advantage and Part D plans to continuously market and enroll beneficiaries throughout the year.

The plans receiving bonus payments are required to use the additional dollars to provide "extra benefits" (such as eyeglasses or transportation to and from the doctor), the Kaiser Family Foundation noted in an analysis of the incentive program last year.

To find the most recent publicly available Medicare Advantage and Part D contract and enrollment data, visit *www.cms.gov/MCRAdvPartDEnrolData/MCESR/list.asp#TopOfPage*.

28090

Emergency Medical Assistance

A Special Note to Our Members
We believe it's important for all of us to become better informed consumers when it comes to selecting coverage. As an eye-care professional and member of the AOA, you have many choices.

This article focuses on the fundamentals of available products and services that can help safeguard your financial security, arrange for your proper medical care and give you greater peace of mind.

Dori Carlson, O. D.
President, AOA

In a medical emergency, where every minute counts, time is precious and acting quickly is essential. However, as medical care, insurance and even traveling get more complicated, cutting through the red tape and getting through to the appropriate people who can help can take hours.

For these reasons, an Emergency Medical Assistance plan would provide you with greater peace of mind, knowing that coordinators are available any time to help you through a travel crisis.

Emergency Medical Assistance is a way to minimize the considerable financial and health-related risks in an emergency, including accidents, illness and emergency evacuation.

Generally, coverage with an Emergency Medical Assistance plan is effective for one year and covers you for medical emergencies when you're traveling for business or vacation. The rates for this type of coverage are usually inexpensive and the cost to cover your entire family is very economical.

Another type of coverage available is specifically designed to cover you only for the duration of your trip, particularly while traveling overseas. Known as "travel insurance," typically this sort of plan covers trip cancellation and interruption, medical evacuation, flight insurance and lost baggage. The cost can be rather expensive at 5%-12% of your total trip cost.

On the other hand, an Emergency Medical Assistance plan commonly provides broader coverage. Any time you're traveling away from home, if you have a medical emergency due to an accident or sudden illness, plan coordinators are ready to help you 24 hours a day.

This is important because, at a time when speed is essential to your recovery, these coordinators can quickly get involved on your behalf to make sure you are getting the proper medical care wherever you are. To help prevent delays or denial of medical care, with your permission, plan coordinators will relay insurance information and provide your medical records to the medical staff treating you. Plan coordinators will also monitor your condition and provide ongoing updates to your family and personal doctor if you wish. This valuable "peace of mind" will help lessen your stress and worry so you can concentrate on a speedy return to good health.

Evacuation coverage is an important part of any Emergency Medical Assistance plan. This benefit pays the cost of getting you to a better hospital where you can receive appropriate medical treatment in the event the local hospital cannot treat you. This covers transportation by ambulance and life flight which aren't usually covered by your regular medical insurance.

Plan coordinators will arrange to bring a specialist doctor to you or move you to a more suitable facility to get the care you need if necessary. Look for an Emergency Medical Assistance plan that not only makes these arrangements for you but pays the costs as well.

Once you're stable and ready to travel, plan coordinators will make arrangements to get you back home to complete your recovery. Look for an Emergency Medical Assistance plan that pays transportation costs for your return home as well as your traveling companion, kids or grandkids if they're left unattended, and your vehicle. Some plans will provide help for your pets.

A good Emergency Medical Assistance plan will offer, at no extra cost, pre-trip consultation such as travel advisories, passport requirements and inoculation information. Other helpful benefits include translation services, assistance tracking lost luggage and arranging for the replacement of lost or stolen passports, airline documents, visas and other documents.

If you are interested in emergency medical coverage or travel insurance, do some homework and find out exactly what the plans cover. Consider the AOA Emergency Assistance Plus Program fully endorsed by AOA. Call toll-free 1-877-883-1924 for more information and let a representative help you choose a plan with benefits that are the best fit for your personal needs.

Index,

from page 7

ices (down from the 6.7 percent increase recorded in 2010).

The 2.2 percent increase in fees for professional services during 2011 reflected a 2.7 percent increase in fees for physicians' services (down from the 3.4 percent increase recorded in 2010).

It also reflected a 2.2 percent increase in fees for dental services (down from a 2.7 percent increase in 2010) and a 1.3 percent increase in fees charged by other medical professionals (which rose 1.8 percent in 2010), as well as the 0.7 percent increase in charges for eyewear and eye care.

Costs for hospital and related services rose due to a 5.8 percent increase in fees for hospital services (which rose 7.6 percent in 2010) and a 2.9 percent increase in costs for nursing home services and adult day care (down from the 3.1 percent increase recorded in 2010), and a 1.9 percent increase in the cost of care for invalids and the elderly at home (up from the 1.5 percent increase recorded in 2010)..

The 5.3 percent increase in costs for hospital services reflected a 6.2 percent increase in fees for inpatient services (down from the 9.2 percent increase recorded in 2010) and a 5 percent increase in fees for outpatient services (down from a 5.1 percent increase in 2010).

Medical care commodities rose 3.2 percent over the course of 2011 as the result of a 3.4 percent increase in the cost of medicinal drugs (up slightly from a 3.1 percent during 2010) and a 0.4 percent decrease in costs for medical equipment and supplies (which decreased 0.1 percent in 2010).

The increase in the cost of medicinal drugs came as the result of a 4.1 percent increase in prices for prescription drugs (identical to

See Index, page 24

SUNY announces optometry career development center

More than 200 students, residents and young alumni attended the State University of New York (SUNY) State College of Optometry's first Career Symposium on Feb. 12, 2012.

In his welcoming remarks, college President David A. Heath, O.D., announced the day-long program was the first step in the establishment of the college's new Career Development Center, which college officials feel will break new ground in programming and services for students.

The center will offer highly personalized and purposeful services to students, residents and alumni by involving them in their own career explorations and deliberations in ways that are uncommon at most American colleges of optometry.

It is a goal of the Career Center's strategic plan to ensure 90 percent of alumni are in positions of choice five years after graduation.

"The establishment of the SUNY Career Development Center has been an important goal of our five-year strategic plan, A Shared Vision. The center represents a heightened institutional commitment to our students and alumni by proactively synchronizing co-curricular opportunities with key career decision points throughout their educational and professional development. The effectiveness of this innovative effort can only be measured by our students' professional success," said Dr. Heath.

Students attending the inaugural symposium were presented with a variety of career options ranging from private practice, Veterans Affairs hospitals and research to positions in industry, academia and community centers.

"Optometry is listed as one of the most popular, dynamic and profitable careers in America today," said Peter Shaw-McMinn, O.D., keynote speaker, national consultant and assistant professor at the Southern California College of Optometry. He added, "This Career Symposium is unique. To my knowledge, no optometry school or college offers this experience to their students. It gives the SUNY students a competitive advantage over students in other schools. I salute SUNY for hitting a home-run."

The three-track program included sessions on leadership skills, financial planning and debt management, practice options, work-life balance and developing a personal brand.

"The process that we went through to develop this symposium proved to be every bit as valuable as the event itself," said Jeffrey Philpott, Ph.D., vice president for Student Affairs and the person responsible for the Center's creation. "What

See SUNY, page 13

American Optometric Association Member Advantage

Endorsed Member Benefit



No matter when or where you have an emergency, your Medical Support Team is ready to assist you

When you have a medical or dental emergency, the AOA EA+ Medical Support Team is ready to assist you, 24 hours a day. No matter where you are, you can count on the team to act quickly because, in a medical emergency, every minute counts …

- To help prevent delays or denial of medical care while traveling, with your permission, plan coordinators can relay insurance information and provide your medical records to the medical staff treating you.

And when the doctor says you're ready, AOA EA+ gets you home after hospitalization to recuperate, if medically necessary, at NO COST TO YOU. If your traveling companion needs help getting home, AOA EA+ will pay their travel expenses as well.

- AOA EA+ can help minimize the considerable financial and health-related risks in an emergency.

Whether you're out of state visiting the grandkids or traveling outside the country, AOA EA+ pays for many emergency expenses that your health insurance usually won't cover such as …

- Life-flight transportation to a more appropriate hospital
- Return-home services for you, your traveling companion, children or grandchildren, your vehicle and even your pets
- Emergency medical monitoring plus updates on your condition will be provided to your family and personal doctor, at your request
- A locator service to find the most appropriate doctor, emergency room or dentist for your situation
- Prescription replacement assistance
- Emergency message relay
- Pre-trip and translation services

For more details, visit www.aoainsurance.com/EAP

We put together a package of essential support services that are vital in an emergency.

Then, we negotiated discounted rates. To cover you for one full year, the cost is just $89!

And it's only $109 to cover your entire family!

That's for a year of AOA EA+ coverage that protects you 24 hours a day when you're traveling away from home.

Act now to secure these low rates. With medical costs rising all the time, this valuable protection is a bargain.

To sign up for coverage or get more details, visit www.aoainsurance.com/EAP. Or call toll-free 1-877-883-1924.

YOU CANNOT BE TURNED DOWN FOR EA+. This is an exclusive AOA program. So we negotiated **guaranteed acceptance** privileges and **low rates** for ALL AOA Doctors of Optometry and their families.

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Visit www.aoainsurance.com/EAP today for more information or to enroll in the plan. Or call toll-free 1-877-883-1924. You can review the AOA EA+ benefits, check out the 100% money-back guarantee and even sign up for coverage. You're guaranteed acceptance!

This information is only an outline of the plan's features. The full terms, benefits and conditions of the plan are shown in your EA+ Plan Description. You must call EA+ at the time of your emergency so we can make the arrangements for you. Please read your plan description carefully.

Medicare offers materials on ACOs, billing error prevention

The Medicare Learning Network (MLN) has released the latest in a series of podcasts designed to provide education on avoiding common billing errors and complying with requirements of the Medicare program.

The "Medicare Overpayment Collection Process" (*www.cms.gov/MLNProducts/MLM/itemdetail.asp?itemID=CMS1254707*) podcast (ICN 907563), posted Dec. 8, 2011, is designed to provide education on the "Medicare Overpayment Collection Process." It includes information from the MLN fact sheet titled "The Medicare Overpayment Collection Process," which describes the collection of Medicare physician and supplier overpayments. Visit the MLN Multimedia Web page (*www.cms.gov/MLNProducts/MLM/list.asp*) to download this and other podcasts from the MLN.

The MLN also encourages practitioners to visit the MLN Provider Compliance Web page (*www.cms.gov/MLNProducts/45_ProviderCompliance.asp*) for the latest educational products designed to help Medicare fee for service (FFS) providers understand – and avoid – common billing errors and other improper activities identified through claim review programs. New MLN podcasts are due for release in the coming months.

The "MLN Advanced Payment Accountable Care Organization Model" fact sheet (ICN 907403) is designed to provide education on the advance payment model for Accountable Care Organizations (ACOs). It includes a summary of the Advance Payment ACO Model, background, and information on the structure of payments, recouping of advance payments, eligibility, and the application process. The fact sheet can be accessed at *www.cms.gov/MLNProducts/downloads/ACO_Advance_Payment_Factsheet_ICN907403.pdf.*

The new "MLN Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program" fact sheet (ICN 907404) provides education on the provisions of the final rule that implements the Medicare Shared Savings Program with ACOs. It includes background, information on how ACOs impact beneficiaries, eligibility requirements to form an ACO, and information on monitoring and tying payment to improved care at lower costs. The fact sheet can be accessed at *www.cms.gov/MLNProducts/downloads/ACO_Summary_Factsheet_ICN907404.pdf.*

The new "Improving Quality of Care for Medicare Patients: Accountable Care Organizations" fact sheet (ICN 907407) is designed to provide education on improving quality of care under ACOs. It includes a table of quality measures under the program. The fact sheet can be accessed at *www.cms.gov/MLNProducts/downloads/ACO_Quality_Factsheet_ICN907407.pdf.*

The new "Medicare Shared Savings Program and Rural Providers" fact sheet (ICN 907408) is designed to provide education on how the Medicare Shared Savings Program impacts rural providers. It includes information on federally qualified health centers, rural health clinics, critical access hospitals, and how this program impacts them. The fact sheet can be downloaded at *www.cms.gov/MLNProducts/downloads/ACO_Rural_Factsheet_ICN907408.pdf.*

The new "Medicare Quarterly Provider Compliance Newsletter" [Volume 2, Issue 2] (ICN 907703) has been released in downloadable format. This educational tool is designed to help practices avoid common billing errors and other erroneous activities when dealing with the Medicare program, and highlights the top issues of the particular quarter. Visit *www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf* to download and print the latest newsletter or search an archive of previously-issued newsletters.

Recently revised MLN products

The revised "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC" booklet (ICN 006973) is designed to provide education on the different CMS claim review programs and assist providers in reducing payment errors, including, in particular, coverage and coding errors. It includes frequently asked questions, resources, and an overview of the various programs, including Medical Review, Recovery Audit Contractor, and the Comprehensive Error Rate Testing Program. The booklet can be downloaded at *www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf.*

The "Medicare Physician Fee Schedule" fact sheet (ICN 006814) has been revised and is now available in downloadable format. It includes information on physician services, therapy services, Medicare Physician Fee Schedule (PFS) payment rates, and the Medicare PFS rates formula. The fact sheet can be downloaded at *www.cms.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf.*

The "Guide to Medicare Preventive Services: Errata Sheet to the Fourth Edition" fact sheet (ICN 907802) has been released and is available in downloadable format. This errata sheet reflects the changes to "The Guide to Medicare Preventive Services" and includes updates such as information on newly covered benefits, updated codes, and resources. Medicare's preven-

See MLN, page 20

Register now for 2012 Medicare EHR program

Optometrists who are now implementing electronic health records in their practices and who have not yet registered for the Medicare EHR Incentive Program should do so as soon as possible, according to the AOA Health Information Technology (HIT) Subcommittee.

Under the incentive program, which went into effect Jan. 1, 2011, health care practitioners can earn up to a total of $44,000 ($48,400 in federally designated health professional shortage areas) over five consecutive years – and up to $18,000 in just their first year of participation.

However, because bonuses will gradually be scaled back over the course of the program, practitioners must register and report compliance with the program's EHR utilization standards during 2012 to receive the maximum possible payments.

Medicare accepts registrations for the EHR incentive program through a designated Registration and Attestation Web site (*https://ehrincentives.cms.gov*).

The registration process takes only about 15 minutes and is not difficult, according to the AOA HIT Subcommittee.

Registration requirements include:

- Basic identification and contact information such as name, street address, telephone number, and email address
- A National Plan and Provider Enumeration System (NPPES) user ID and password
- A complete and up-to-date listing in the Medicare P Provider Enrollment, Chain and Ownership System (PECOS) enrollment database
- A National Provider Identifier (NPI) number.

Practitioners should make sure they have all the required information at hand when attempting to register, the CMS emphasized.

Practitioners can request a NPPES ID and password via the NPPES Web site (*https://nppes.cms.hhs.gov*); however, because practitioners may need to mail some documentation, the process can take several weeks.

By registering as soon as possible this year, practitioners can ensure they have time to rectify any problems that may be encountered in the course of the registration process, the AOA HIT Subcommittee noted.

They can also ensure they will have as many 90-day reporting periods as possible during 2012 in which to achieve meaningful use.

Before attempting to achieve compliance with the EHR utilization standards during a reporting period, practitioners should check to ensure they have properly installed a complete EHR system certified for use in the incentive program, have an active e-prescribing solution, and understand the required meaningful use criteria they will have to meet.

For additional information, see the AOA website EHR page (*www.aoa.org/EHR*).

Optometry loses one of its greatest: Dr. Irvin Borish

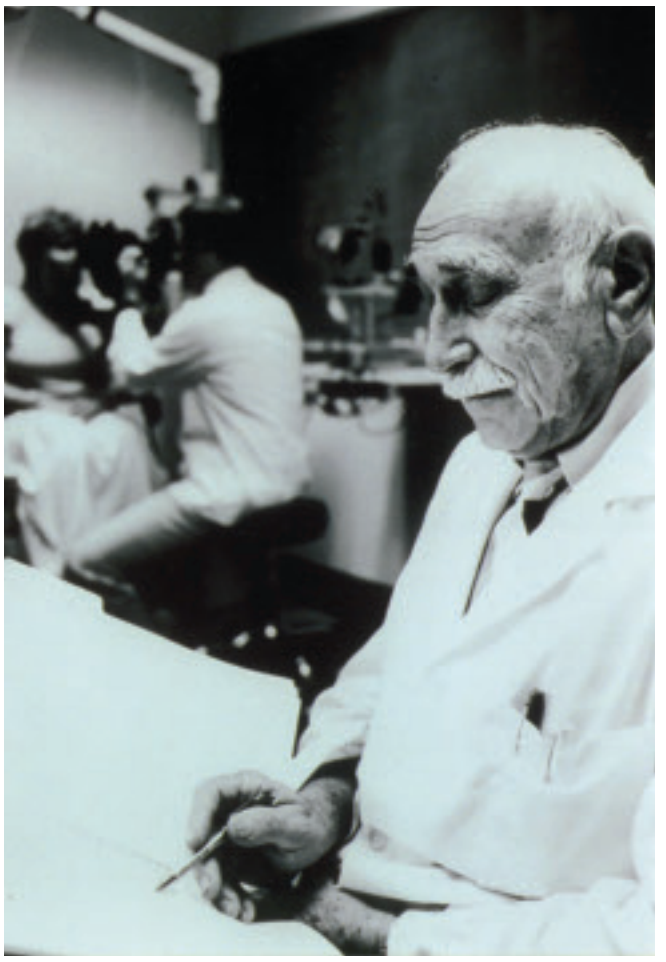
The "Father of Clinical Optometry," Irvin Borish, O.D., DOS, died earlier this month. He was 99.

Dr. Borish was from Pennsylvania and graduated from the Northern Illinois College of Optometry in 1934. He was on the school's faculty for eight years, serving as director of clinics, before leaving for private practice in Indiana in 1944. He was instrumental in starting the Indiana University School of Optometry and the Association of Schools and Colleges of Optometry.

Dr. Borish authored many of the textbooks used in every optometry school in the country. He was granted five patents for contact lenses. He was a founding member of the Indiana Chapter of the American Academy of Optometry, was a president of the Indiana Optometric Association and the editor of the *Indiana Journal of Optometry*. He served as adjunct faculty at many of the optometry schools.

He served as chair of the AOA Publications Committee and Commission on Optometric Technology. Among his many awards and achievements, he was the recipient of the prestigious AOA Apollo Award for the visual betterment of mankind in 1968 and the AOA Distinguished Service Award in 1989. He was inducted into the National Optometry Hall of Fame in 1998. He painted in his spare time.

"I was fortunate to have known him for over 40 years, and I have the original edition of 'Clinical Refraction' by Borish that my father was studying for finals when I was born," said AOA President-elect Ron Hopping, O.D., MPH. "I was particularly fortunate to teach with him while we were both on faculty at UHCO, and he taught me many things about life, leadership and the love of our profession. The last time I spent an evening with him was two years ago, and it was just my dad, Irving and myself. We closed the restaurant down, and I listened as the two of them told story after story about our profession's heritage. They were both very young at heart that night. Dr. Borish had strong beliefs about how to move this then-fledgling profession forward, and I am truly amazed by the number of things in our profession that he touched – beyond refraction and his original contact lens designs."



Dr. Borish

President,

from page 4

Getting started is easy. Ask an AOA volunteer how you can get involved or just pick up the phone and call your AOA. One of the most effective ways to fight for patients and the profession is to attend the AOA Congressional Advocacy Conference. This year it's April 1-3 and may very well be one of the most critical conferences in recent years. While we've made some great strides in recent years, our work is far from over. With so much at stake, will you commit to being one of the doctors who helps?

Hope to see you this April in the nation's capital.

Dori Carlson, O.D.
AOA president

SUNY,

from page 11

impressed me most was the way the entire college community came together to assess the need for career development and to respond by creating such a high caliber event."



Vice President for Student Affairs Jeffrey Philpott, Ph.D., left, talks with a SUNY student at the symposium.



From left, Peter Shaw-McMinn, O.D., keynote speaker, and College President David A. Heath, O.D., at the SUNY symposium.

AOA hosts veterans health care leaders for talks on eye care access



Barry Barresi, O.D., executive director of the AOA, second from left, welcomed Rep. Jeff Miller (R-Fla.), chairman of the U.S. House Committee on Veterans Affairs (VA), second from right; Tom Zampieri, acting executive director of Blinded Veterans Association (*www.bva.org*), on left; Donald Simpson, O.D., representing the National Association of VA Optometrists, on right; and Rep. Todd Akin (R-Mo.), Armed Services subcommittee chair, to the AOA's headquarters for a briefing on optometry's essential role in caring for America's current and former military service personnel. Following discussions about optometric education and the AOA's efforts to safeguard veterans' access to eye care, Dr. Barresi and presented Rep. Miller with the AOA Veterans Health Care Leadership Award in recognition of his strong support for VA optometry.

AOA expert helps make PQRS simple

By Rebecca H. Wartman, O.D., AOA Practice Advancement Committee

The Physician Quality Reporting System (PQRS, or formerly PQRI) has been in existence since 2007. The past five years have seen an evolution in this program. Luckily for optometry, there have been few changes in the past two to three years, making it easier for us to become successful in reporting.

Successful reporting means recognition for providing quality care for the individual doctor and for the optometric profession, as well as more dollars in the coffers of the optometrist.

The 2012 PQRS measures for optometry have few changes from 2011 reporting requirements. To be successful in reporting for 2012, the provider must choose at least three PQRS measures and report them consistently on at least 50 percent of the appropriate claims.

However, this does not mean a provider needs to file three different PQRS measure on each claim.

For PQRS reporting, there are three different diseases that should be of concern to the optometrist: age-related macular degeneration, glaucoma and diabetes. *(See diagnosis chart on page 16.)*

The only examination codes of consequence when considering PQRS reporting are the evaluation and management (E&M) codes to report examinations, including 99201-99205 and 99212-99215 (and other E&M codes such as nursing home or rest home E&M codes) and/or the general ophthalmic examination codes (92002, 92012, 92004, and 92014). Other eye care procedures do not trigger opportunities for reporting.

Once a provider has a patient with traditional Medicare or Railroad Medicare AND that patient has one of the three diseases AND the patient is billed using an E&M code or a general ophthalmic visit code, then a PQRS measure should be considered.

The bonus payment for successfully participating in the 2012 PQRS will be 0.5 percent of a practitioner's entire Medicare allowables filed for 2012.

The bonus applies to any and all Medicare claims filed by a provider, with or without a PQRS measure attached.

Why should optometrists be participating in the PQRS program for a small bonus payment? Consider what the Centers for Medicare & Medicaid Services (CMS) is telling our patients. On the Physician Compare website, Medicare lists the practitioners who have successfully participated in PQRS for 2010 with the following statement: "This professional chose to take part in Medicare's Physician Quality Reporting System and reported quality measure information satisfactorily for the year 2010."

The CMS further states, "A physician or other health care professional can choose whether to report quality information to Medicare under the Physician Quality Reporting System. Medicare believes that reporting quality information by professionals is an important means to improve the quality of care provided to Medicare beneficiaries."

This last statement gives the distinct impression that providers who participate in this program provide better care than those providers who do not participate. Patients are reading this information and making judgments on the quality of care.

Patients read this information and make judgments on the quality of care.

Eventually, the CMS will provide reports to patients on actual performance under PQRS.

How did optometry perform in 2010? In 2010, 1,381,276 quality data codes (QDCs) were submitted by optometry, with 81.15 percent of the codes correctly applied. Compare this to 5,119,625 codes submitted by ophthalmology with 87.42 percent of the codes correctly applied.

Overall, the optometrists who reported PQRS codes were successful. The majority of the errors were from inappropriate diagnosis codes being submitted with PQRS codes.

The numbers reported to date for the 2011 PQRS year just ended are very similar to the 2010 numbers.

However, more optometrists should earn the PQRS bonus because 2011 was the first year the threshold for successful reporting dropped from 80 percent correct to 50 percent correct submission of at least three measures.

The payments for the 2011 PQRS will not be sent until sometime in the third quarter of 2012 (if past payment times are any indication).

PQRS 2012 measure details

Nine eye care measures were retained for 2012, and two new measures were added. Optometry only needs to be concerned with seven of these measures.

- Measure 12 –Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
- Measure 14 – Age-Related Macular Degeneration (AMD): Dilated Macular Examination
- Measure 18 – Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Measure 19 – Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- Measure 117 – Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
- Measure 140 – Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
- Measure 141 – Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15 percent OR Documentation of a Plan of Care

Measure numbers refer to the order of the measures listed in the original CMS documents and are not meant to be used to report the measures.

The other four PQRS codes are registry-only codes and are not really meant for use by optometry. The retained codes are cataracts codes for surgeons (#191 and #192). The new PQRS codes are cataract outcomes by patient report (#303 and #304).

Details of the PQRS 2012 codes specific to eye care by disease

Again, all of the eye care-specific PQRS measures are applied when the provider is coding an evaluation and management code (99211-99205, 99212-99215) or a general ophthalmic visit code (92002-92014).

The evaluation and management codes for nursing home, rest home and others are also included (see the box on page 16 for a complete listing).

The PQRS measures do not apply to any special ophthalmic service codes such as scanning laser, visual fields, and photography.

Macular Degeneration

There are two measures for the diagnosis of macular degeneration. If any of the following three AMD diagnoses are coded, the provider may use one or both of these measures. The patient also needs to be age 50 or older.

- 362.50 Macular Degeneration, NOS
- 362.51 Macular Degeneration, non-exudative
- 362.52 Macular Degeneration, exudative

Measure #14, using the QDC 2019F, indicates the provider had a dilated view of macula AND documented whether macular thickening and hemorrhages were present or not present.

The provider must dilate and record the finding once per 12-month period or once per reporting period.

However, the QDC must be used on every claim submitted for the AMD diagnosis, even if the dilated macular examination was performed during a prior patient visit.

The exceptions for 2019F are:

- 1P: medical reason for no dilated macula view
- 2P: patient reason for no dilated macula view
- 8P: other reason for no dilated macula view

An exception would be used only if the provider could not complete the measure requirements for the reason attached to the exception. The exception is indicated using the 1P, 2P or 8P as a modifier to the QDC.

Measure #140, using the QDC 4177F, indicates the provider discussed the pros and cons of the Age-Related Eye Disease Study (AREDS) formulation of antioxidant supplements and made prop-

See PQRS, next page

PQRS,

from previous page

er recommendations for individual and documented discussion per the AREDS report (*www.aoa.org/PQRS*).

This discussion and documentation of recommendations must occur once per 12-month period or once per reporting period for each unique patient. However, the QDC must be used on every claim submitted for the AMD diagnosis even when the AREDS discussion occurred during a prior patient visit.

The only exception for 4177F is 8P: no reason for not discussing AREDS.

Primary Open-Angle Glaucoma

There are two measures for the diagnosis of glaucoma. If any of the following glaucoma diagnoses are coded, the provider may use one or both of these measures. The patient must be age 18 or older.

- 365.10 Open-Angle Glaucoma, unspecified
- 365.11 Primary Open-Angle Glaucoma
- 365.12 Low-Tension Glaucoma
- 365.15 Residual Open-Angle Glaucoma
- 365.70-365.74 (new codes used in conjunction with regular glaucoma diagnoses)

Measure #12, using the QDC 2027F, indicates the provider viewed optic nerve with or without dilation. The provider must document the results of the optic nerve view once per 12-month period or once per reporting period for each unique patient. However, the QDC must be used on every claim submitted for the glaucoma diagnosis even when the optic nerve view occurred during a prior patient visit.

The exceptions for 2027F are:

- 1P medical reason for not viewing optic nerve
- 8P no reason for not viewing optic nerve

Measure #141 has three different codes to consider with several different code combinations. QDC 3284F is used to indicate when the intraocular pressure (IOP) was reduced 15 percent or more from pre-intervention levels. QDC 3285F is used when IOP was NOT reduced 15 percent from pre-intervention levels AND 0517F is added to indicate a plan of care to get IOP reduced is in place.

The exceptions are as follows:

- 3284F: 8P IOP not documented, no reason given
- 3285F: No exceptions because a practitioner would use 3284F- 8P if the IOP was not measured.
- 0517F: 8P no plan of care documented to reduce the IOP.

For QDC 0517F, a plan of care might consist of a plan to recheck IOP at specified time, a change in therapy, a plan to perform additional diagnostic evaluations, monitoring of IOP per patient decisions, indication that the target IOP was unable to be achieved due to health system reasons or a referral to a specialist.

Again, any plan of care should be documented in the patient record.

See PQRS, next page

Primary open-angle glaucoma codes

- Controlled IOP: Use 3284F
- Uncontrolled IOP: Use 3285F and 0517F
- No IOP measured: Use 3284F-8P alone
- Uncontrolled IOP but no plan of care: Use 3285F and 0517F-8P

IN 1508 LEONARDO DA VINCI SAW THE FUTURE...



(In 1508 Leonardo da Vinci first illustrated the concept of contact lens)

PQRS,

from previous page



An eyecare OptometricAssociation

2012 PQRS EYE CARE MEASURES FOR OPTOMETRISTS

(See https://www.aoa.org/PQRS for more information)

Modifiers are used in PQRS reporting only if the reported measure was not performed during the visit. These modifiers indicate why a measure was not done.

Measure	CPT II	Code Description	Age	ICD 9 CM	CPT I	Modifiers
12 POAG: Optic Nerve Evaluation	2027F	POAG: Optic Nerve Evaluation	18 +	365.10, 365.11 365.12, 365.15 365.20-365.24	92002-92004, 99201-99205, 99212-99215, 99304-99310, 99324-99328, 99334-99337	1P: Medical reason 8P: Reason not specified
14 AMD: Dilated Eye Exam	2019F	AMD: Dilated Macular Exam Performed	50 +	362.50-362.52	92002-92004, 99201-99205, 99212-99215, 99304-99310, 99324-99328, 99334-99337	1P: Medical reason 2P: Patient reason 8P: Reason not specified
18 DR: +/- Macular Edema	2021F	Diabetic Retinopathy: Documentation of +/- Macular Edema and Level of Severity of Retinopathy	18 +	362.01-362.06	92002-92004, 99201-99205, 99212-99215, 99304-99310, 99324-99328, 99334-99337	1P: Medical reason 2P: Patient reason 8P: Reason not specified
19 DR: Communication with MD	5010F + G8397 Or G8398	Diabetic Retinopathy: Findings of dilated macular or fundus exam communicated with the physician responsible for managing ongoing diabetes care Dilated macular or fundus exam performed and documented DR +/- ME Dilated macular or fundus exam NOT performed	18 +	362.01-362.06	92002-92004, 99201-99205, 99212-99215, 99304-99310, 99324-99328, 99334-99337	1P: Medical reason 2P: Patient reason 8P: Reason not specified
117 DM: Dilated Eye Exam	2022F 2024F 2026F 3072F	Diabetes Mellitus: Dilated eye exam in a diabetic patient 7 field photos by OD/DMD for DM Eye imaging validated for DM Low risk retinopathy for DM, e.g. no retinopathy in previous year	18 - 75	250.00-250.03, 250.10-250.13, 250.20-250.23, 250.30-250.33, 250.40-250.43, 250.50-250.53, 250.60-250.63, 250.70-250.73, 250.80-250.83, 250.90-250.93, 357.2, 362.01-362.07, 366.41, 648.01-648.04	92002-92004, 99201-99205, 99212-99215, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350,	8P: Reason not specified 8P modifier not used with 3072F)
140 AMD: AREDS	4177F	AMD: Counseling on Antioxidant Supplement, Inc. per AREDS recommendations	50 +	362.50, 362.51, 362.52	92002-92004, 99201-99205, 99212-99215, 99307-99310, 99324-99328, 99334-99337	8P: Reason not specified
141 POAG: IOP	3284F OR 0517F + 3285F	POAG: Reduction of IOP greater than or equal to 15% pre-intervention level POAG: Reduction of IOP less than 15% pre intervention level, with plan of care in place	18 +	365.10, 365.11, 365.12, 365.15 365.20-365.24	92002-92004, 99201-99205, 99212-99215, 99307-99310, 99324-99328, 99334-99337	8P: Reason not specified

Diabetes

Three different measures are in place for a patient with diabetes, either insulin-dependent or non-insulin-dependent that include measures #18, #19 and #117.

Measure #18, using QDC2021F, is used only with diabetes when retinopathy is present.

The provider must perform a dilated macular or fundus examination and document the presence or absence of macular edema and the level of diabetic retinopathy. This measure is only used when there is diabetic macular edema or diabetic retinopathy. The patient must be 18 years or older.

The following diabetic retinopathy diagnoses are the only ones applicable to this measure:

- 362.01 Background Diabetic Retinopathy
- 362.02 Proliferative Diabetic Retinopathy
- 362.03 Nonproliferative Diabetic Retinopathy, not otherwise specified
- 362.04 Mild Nonproliferative Diabetic Retinopathy
- 362.05 Moderate Nonproliferative Diabetic Retinopathy
- 362.06 Severe Nonproliferative Diabetic Retinopathy

The exceptions for 2021F are as follows:

- 1P medical reason for not documenting macular edema and diabetic retinopathy
- 2P patient reason for not documenting macular edema and diabetic retinopathy
- 8P no reason for not documenting macular edema and diabetic retinopathy

Measure #19 uses three different QDCs. QDC 5010F indicates the provider communicated the presence or absence of macular edema and the level of diabetic retinopathy to physician responsible for the diabetic care. The same list of diabetic retinopathy diagnoses listed for measure #18 applies to this measure. Again, the patient age range is 18 years or older for this measure. In addition, the provider needs to indicate if a dilated macular or fundus examination was performed.

The QDC options for this information are G8397, indicating the dilated macular or fundus exam was performed, OR G8398, indicating the dilated macular or fundus exam not performed.

There are no exceptions for G8397 and G8398. The exceptions for 5010F are:

- 1P medical reason for not communicating
- 2P patient reason for not communicating
- 8P no reason for not communicating

Measure #117 uses one of four QDCs to indicate a dilated diabetic examination was performed. This measure is only used for patients age 18 to 75. And this measure is used for an expanded list of diagnoses. Any of these diabetes diagnoses apply to this measure:
250.00-250.03, 250.10-250.13, 250.20-250.23, 250.30-250.33, 250.40-250.43, 250.50-250.53, 250.60-250.63, 250.70-250.73, 250.80-250.83, 250.90-250.93, 357.2, 362.01-362.07, 366.41, 648.01-648.04.

Providers should use one of the following QDCs to report this measure:

- QDC 2022F is used to indicate a dilated eye exam was performed in a diabetic patient.
- QDC 3072F would be used when the patient is at low risk for diabetic retinopathy (meaning that patient had a normal examination without diabetic retinopathy within the last year).

Two other codes for imaging views of the retina exist for this measure, but are not commonly used by eye care providers. QDC 2024F would be used for reporting that seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist were documented and reviewed. QDC 2026F would be used to indicate eye imaging was validated to match diagnosis from seven standard field stereoscopic photos results that were documented and reviewed. As most optometrists perform dilated diabetic examinations, 2022F would be the most common QDC used to report this measure.

When thinking about the seven QDC measures applicable for eye care providers, it is helpful to consider these measures by disease.

For example, when seeing a patient with AMD who is 50 or older, a provider would typically perform a dilated macular examination at least yearly and discuss the AREDS formulation of supplements at least yearly. Thus, the provider could easily code 2019F and 41277F together for all the AMD patients each and every time this AMD diagnosis is coded and sent to Medicare.

Similarly, with a glaucoma patient who is 18 years or older, the provider typically would perform an optic nerve evaluation at least yearly and would measure the intraocular pressure at least yearly. In addition, when the IOP is not controlled, a provider would typically develop a plan to reduce the IOP to an acceptable level. Coding 2027F and 3284F for a controlled glaucoma patient or 2027F, 0517F and 3285F together for an uncontrolled glaucoma patient would not be difficult.

Diabetic patients present a little more challenge in properly applying the PQRS measures. Age is a key to properly applying these measures.

Any diabetic patient, with or without diabetic retinopathy, between 18 and 75 years, would have QDC 2022F coded to indicate a dilated eye examination was performed (assuming the provider would typically dilate all diabetic patients yearly).

In addition, when diabetic retinopathy with or without macular edema is found, the provider would use 2021F to indicate a dilated macular or fundus examination was performed. Use 5010F to indicate a report was sent to the provider caring for the diabetes along with G8397 to again indicate the dilated macular or fundus examination was performed.

Note that it is the best practice for an eye care provider to communicate with all physicians caring for the diabetic patient, but PQRS only addresses this report when diabetic retinopathy and/or macular edema are found. Also note any and all exceptions to the examples above for all the measures would be reported using the appropriate modifiers listed earlier in this article.

PQRS is not difficult. Consistency is the key to participating and earning the bonus payments and avoiding penalties in the future if a provider does not participate.

Providers should use the summary sheet developed by the AOA when seeing patients and coding examinations to make the process easier (*www.aoa.org/PQRS*).

Happy coding…

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You can learn more about how 3-D relates to the future of optometry during our 3-D Education Syposiums including a special Saturday 3-D Symposium presented to you at no additional cost. These sessions are open to all and will provide an excellent introduction to this growing technology.

Rapid-Fire Facts

If you're a fan of the fast-paced question-and-answer format familiar from sports TV shows, you won't want to miss our "Pardon the Objection" courses. Instead of long lectures, you'll be treated to panel discussion and debate on a new topic every few minutes — with a graphic "rundown" of yet-to-be-discussed topics just like you see on TV.

Each "Pardon the Objection" presentation will feature noteworthy experts engaging in lively give-and-take. Five courses will be presented in this unique style:

- Anterior Segment— presenting a wide range of content highlighting new developments in anterior segment disease, diagnosis, and treatment. The scheduled panel includes Paul Karpecki, O.D., Mile Brujic, O.D., David Kading, O.D., Blair Lonsberry, O.D., and Bill Townsend, O.D.
- Contact Lens — taking a 360-degree view of new developments in contact lens technology. The scheduled panel includes Lamar Zigler, O.D., Joe Shovlin, O.D., Chris Sindt, O.D., and Louise Sclafani, O.D.
- Glaucoma — covering the latest updates and controversies on glaucoma diagnosis and management. The scheduled panel includes Ben Gaddie, O.D., Michael Chaglasian, O.D., Mark Dunbar, O.D., and John Flanagan, O.D.
- New Technology — offering a comprehensive look at new technologies available to the eye care practitioner. The scheduled panel includes Derek Cunningham, O.D., Marc Bloomenstein, O.D., and Dave Geffen, O.D.
- Student Practice Management — focusing on various areas of interest to new practitioners. The scheduled panel includes Derek Hamilton, O.D., Ryan Parker, O.D., and Gina Wesley, O.D.

Cell phones: please leave ON

New this year, Optometry's Meeting® will present interactive sessions on multiple topics, allowing audience members to participate in real time. You can use most smartphones during these select sessions to ask panelists questions, suggest discussion topics, and take real-time surveys — all promising to make these sessions exceptionally relevant.

Learn while you lunch

Also new this year are two Saturday Lunch Symposiums that provide a convenient setting to catch up on what's new. Space is limited, so be sure to register early for either session:

- Tips to Maximize your Multifocal Soft Lens Fitting Success will describe the various multifocal soft contact lens options for our presbyopic patients. There will be a discussion of the features of these multifocal designs and an explanation of how to clinically evaluate and solve problems associated with each design. Sponsored by CooperVision.
- New Developments in Allergic Eye Disease Management and Treatment will provide practical clinical pearls for the effective management of seasonal and perennial allergies, giant papillary conjunctivitis (GPC), vernal keratoconjunctivitis (VKC), and atopic keratoconjunctivitis (AKC). Sponsored by ISTA Pharmaceuticals.

In addition, our popular Breakfast Symposiums will return on Thursday, Friday and Saturday featuring a variety of topics. See the Preliminary Program to get more details on times, subjects, and our generous sponsors.

Practices made perfect

If you are looking to buy, buy-in or sell a practice, our two-part Practice Pathways course is tailor-made for your needs. You'll discover how to be successful in each stage of the practice lifecycle, including practice entry, practice management, development planning and succession planning.

All attendees can attend Practice Pathways at no additional charge.

High societies

As the pioneer of the partnership with professional societies, Optometry's Meeting® is once again giving you the chance to increase your knowledge in specific areas of optometry. Based on the success of this program in 2011, we have integrated additional education from six partners into our overall education program.

The participating societies include:

- Vision Leads Foundation
- Optometric Glaucoma Society
- Optometric Council on Refractive Technology
- Optometric Retina Society
- Ocular Surface Society of Optometry
- College of Optometrists in Vision Development

CE for free

As always, Optometry's Meeting® offers more than 30 hours of free continuing education, with different opportunities every day. Just two of our new offerings include:

- Fitting Beyond the Ordinary is scheduled for Wednesday, June 27 from 4 p.m. to 6 p.m. (course #0800). This course will present a variety of complex and interesting contact lens cases. In each scenario, a comprehensive treatment protocol will be employed, including therapeutic agents, contemporary contact lens designs, and the appropriate lens care regimen. The emphasis will be on using a creative and rationale approach to alleviating contact lens dropout. Sponsored by Abbott Medical Optics and CooperVision.
- The 3-D Experience: Movies, Television, Video Games and in the Classroom — When Our Eyes Fail Us is scheduled for Saturday, June 30 from 8 a.m. to 11:30 a.m. (course #D201). Depth perceived in 3-D movies, television, video games, and classroom education is different than in the real world. Some viewers have eyestrain, blur, diplopia, and vertigo; others can't appreciate the depth. This course provides a framework for understanding diagnostic and therapeutic strategies for managing anyone with 3-D vision syndrome.

Optometry's Meeting® would like to recognize the optometric education program is generously co-sponsored by the Illinois Optometric Association.

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MLN,

from page 12

tive services program includes glaucoma screening. The fact sheet can be downloaded at *www.cms.gov/MLNProducts/downloads/MPS_Guide_errata_factsheet_ICN907802.pdf.*

The "Guidelines for Teaching Physicians, Interns, and Residents" fact sheet (ICN 006347) has been revised and is now available in downloadable format. It includes information about payment for physician services in teaching settings, general documentation guidelines, and evaluation and management documentation guidelines. The fact sheet can be downloaded at *www.cms.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf*

The new "Preventive Services Educational Resources for Health Care Professionals MLN Matters® Special Edition Article" (#SE1142) is designed to provide education on available educational resources related to Medicare-covered preventive services.

It includes a list of MLN products that can help Medicare FFS providers understand coverage, coding, reimbursement, and billing requirements related to these services. The special edition article can be downloaded at *www.cms.gov/MLNMattersArticles/Downloads/SE1142.pdf.*

A new MLN Matters® Special Edition Article #SE1202, "Health Professional Shortage Area (HPSA) Bonus Payment Policy Reminders," has been released in downloadable format. This article is designed to provide education on the HPSA Bonus Payment Program, and provides information about the program and resources that providers can use to determine whether they are eligible to receive the bonus payment. It can be downloaded at *www.cms.gov/MLNMattersArticles/Downloads/SE1202.pdf.*

MLN Matters Special Edition Article #SE1201, "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers," has been released in downloadable format. This article is designed to provide education on policy that says Medicare will only pay for specific items or services that are ordered or referred by providers or suppliers who are enrolled in Medicare and authorized to do so. It includes information about what providers should know before submitting a claim and limitations to the policy. The special edition article can be downloaded at *www.cms.gov/MLNMattersArticles/Downloads/SE1201.pdf*

The Medicare Learning Network offers official U.S. Centers for Medicare & Medicaid Services information for Medicare fee-for-service providers, designed to help increase understanding of the Medicare program and stay current on program policy changes, and to provide the information needed to bill correctly. An overview of MLN resource can be on the program's Web site *(www.cms.gov/MLNgeninfo)*.

Advancing Optometry Worldwide

Program, speakers announced for international conference

The World Council of Optometry (WCO) published its program for Advancing Optometry Worldwide, its next conference, to be held in Chicago.

The conference, taking place at the Renaissance Blackstone Hotel, June 24-26, 2012, will bring together eye care professionals, optometrists, academics and students from around the world.

The program features speakers from around the globe, including:

- Professor Kovin Naidoo, African chair of the International Agency for the Prevention of Blindness (IAPB) and Global Programmes director of the International Centre for Eyecare Education (ICEE)
- Pete Kehoe, O.D., past president of the AOA
- Professor Thomas Freddo, University of Waterloo, Canada
- Clive Miller, chief executive officer of Optometry Giving Sight
- Prema Chande, Lotus College of Optometry, India

"I would encourage eye care professionals who are looking to extend the scope of practice in their country to come along to Advancing Optometry Worldwide," said Tone Garaas-Maurdalen, WCO president. "This conference will be a chance to share experiences and learn from other professionals who may work in an environment very different from yours, with different challenges, successes and opportunities."

The program also includes:

- Workshops at the Illinois College of Optometry on fundus lenses, gonioscopy and binocular indirect ophthalmoscopy
- Breakout sessions on web-based instruction and optometric volunteering
- Lectures on managing diabetes and the eye in neurological disease.

"This event will feature an exciting program of lectures from world-class speakers and sessions for delegates to question leaders in optometry from around the world," said Susan Cooper, O.D., WCO president-elect. "Networking and sharing our own experiences will ensure we all play a role in advancing optometry worldwide."

Log on to *www.worldoptometry.org* or follow on Facebook at *www.facebook.com/WorldCouncilOpt* to download the program and receive up-to-date news and announcements on Advancing Optometry Worldwide as they happen.

Bookings are open now.

Bonuses,

from page 1

The CMS/ONC data indicates more than half (638) of the optometrists who qualified for EHR incentives during 2011, did so during the last month of the year. Some close to the EHR industry believe a like number of optometrists may have filed for EHR incentives in a similar "last-minute rush" during the January-February grace period.

The CMS is scheduled to release a year-end report with final totals for the 2011 Medicare EHR Incentive Program in the coming weeks.

All practitioners who qualified for EHR incentives during 2011 will receive payment no later than April, according to the CMS.

Like earlier CMS data (see *AOA News*, February), figures released last month for the first full year of the Medicare EHR Incentive Program show only a handful of, generally, much larger health care professions have seen more practitioners qualify for Medicare EHR incentives than optometry.

Optometrists are among the top half-dozen health care specialties in terms of successful EHR utilization – and easily the leaders in eye care. Optometrists continue to qualify for Medicare EHR incentives at roughly twice the rate of ophthalmologists, the new data show.

"This is wonderful news," said AOA President Dori Carlson, O.D. "It means that optometrists are acting quickly and implementing EHRs while they can still realize the maximum benefits from the incentive program."

Under the Medicare EHR Incentive Program, which went into effect Jan. 1, 2011, health care practitioners can earn up to a total of $44,000 ($48,400 in federally designated health professional shortage areas) over the six-year life of the program if they install EHR systems that are certified for use under the program and achieve compliance with the program's EHR utilization criteria, known as "meaningful use" standards.

Practitioners who entered the program during 2011 or enter during 2012 can earn up to $18,000 during their first year of participation.

During those calendar years, incentive payments for first-time participants are based on 75 percent of the participant's total Medicare allowed charges for the year, up to a billing threshold of $24,000.

Maximum first-time incentive payments for those entering the program during the period 2013-2015 will be reduced substantially each year.

Practitioners will not be allowed to enter the incentive program after 2015.

For additional information on the Medicare EHR Incentive Program, see the AOA website EHR page (*www.aoa.org/ehr*).

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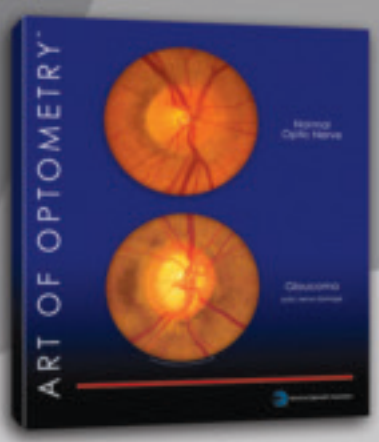


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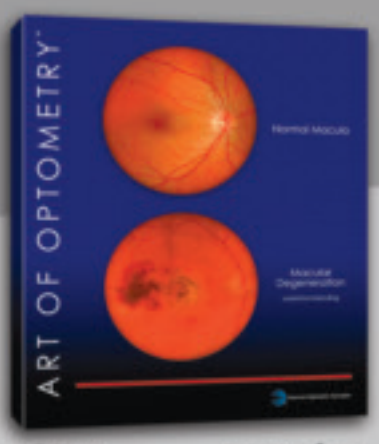
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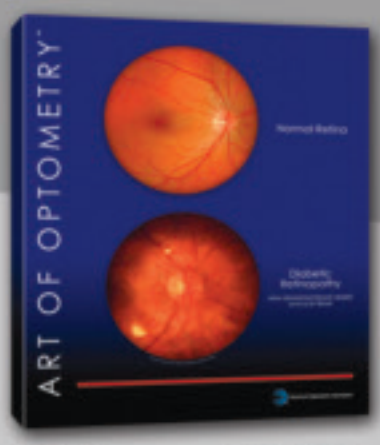
GP-5 *Glaucoma*



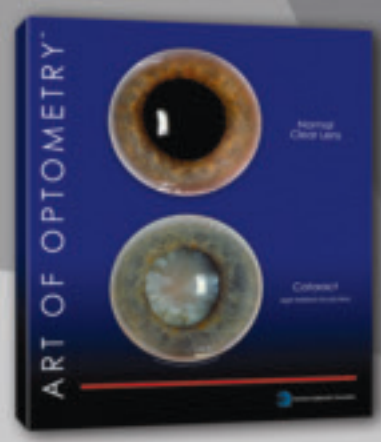
GP-6 *Macular Degeneration*



GP-9 *The Human Eye*



GP-7 *Diabetic Retinopathy*



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ICO partnership with school-based eye clinic confirms needed service for 5,000 students

The Illinois College of Optometry announced its partnership with the Chicago Public Schools (CPS) to open a school-based eye clinic has resulted in treatment for more than 5,000 CPS students in the year since it opened.

The clinic at Princeton Elementary School on the city's South Side was established in January 2011 as part of Chicago Vision Outreach, a program that provides charitable eye health and vision care to Chicago's underserved populations.

It is the first known model in the nation to deliver eye care services year-round to an urban school district.

The CPS estimates 25 percent of its students fail vision screenings each year, have broken or lost glasses, or fail to get the eye exam mandated by law to enter an Illinois school system.

"During the last year, we have seen a lot of children with significant vision problems. Some children were using friends' or siblings' glasses, and some kids had eye health issues that had never been identified or had been identified, but never treated," said Sandra Block, O.D., ICO professor and medical clinic director. "The clinic is part of a solution to address the unmet need of vision care for children within the city of Chicago; it is helping to eliminate one barrier to improved academic performance for many students."

The clinic is outfitted with 13 professional eye exam lanes and is open Monday to Friday, 8:30 a.m. to 12:30 p.m. ICO students provide much of the clinical care under the supervision of experienced optometrists, and the more complex cases are referred to the Illinois Eye Institute, ICO's clinical facility, for further testing.

Data gathered from the student visits this past year demonstrate the great need for the clinic.

"Some children were using friends' or siblings' glasses, and some kids had eye health issues that had never been identified or had been identified, but never treated."



Chicago Public School students are fitted with their new eyewear.

Approximately 75 percent of the treated children needed new or replacement glasses.

Strabismus was present in 6.2 percent of the students, and amblyopia was identified in 8.5 percent.

Previously undiagnosed glaucoma was found in two cases.

Melissa Coleman, an optician at the clinic, said it has been a very rewarding experience to deliver new glasses to the students.

"They've been going so long without being able to see properly," said Coleman. "Most of the time they say 'Wow! Everything looks so big and so close to me!'"

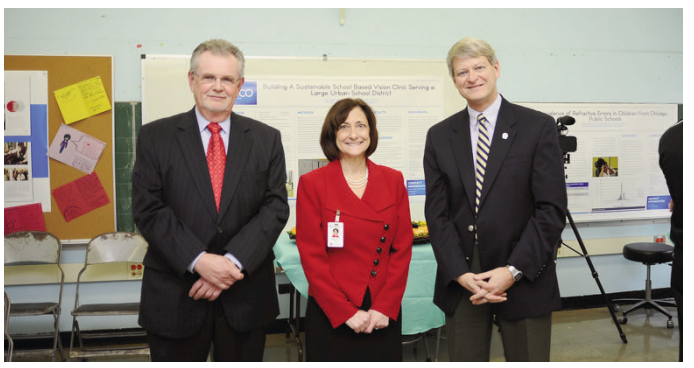
The program is currently funded through state reimbursement and private grants from the Lloyd A. Fry Foundation, the Chicago Community Trust, Alcon and Blue Cross and Blue Shield of Illinois.

A complete list of supporting organizations and individuals is available by visiting *www.ico.edu*.

A video clip of Dick Smith, Ph.D., chief officer of the Office of Special Education and Supports with the Chicago Public Schools, commenting about the clinic and impact to the school system is available at *http://tinyurl.com/6wj53fc*.



CPS students created thank you notes for the staff and students of ICO's school-based clinic.



From left, ICO's John Budzynski, Sandra Block, O.D., and Mark Colip, O.D.



From left, Arol Augsburger, O.D. (ICO), Dick Smith, Ph.D. (CPS), Stephanie White, Ph.D. (CPS), Katheryn Stafford-Hudson (CPS) and Sandra Block, O.D. (ICO).



Clinic Director Sandra Block, O.D., center, gives a tour of the school-based clinic for Chicago Public Schools, Good-Lite and ICO officials.

Ala., N.H., Tenn. to offer EHR courses

The AOA's new "Navigating Meaningful Use, Quality Reporting, and e-Prescribing with Electronic Health Records (EHRs)" continuing education (CE) courses will be offered during at least 23 state or national optometric association meetings this year, according to the AOA Clinical and Practice Advancement Group (AOA-CPAG).

The Alabama Optometric Association and Tennessee Association of Optometric Physicians will both offer Navigating with EHRs courses May 5 as part of their annual meetings. The New Hampshire Optometric Association will offer a Navigating with EHRs course May 9 during its annual meeting.

Navigating with EHR courses will also be offered as part of the continuing education program at this year's Optometry's Meeting®, June 27 – July 1, in Chicago. The Optometry's Meeting® courses will be offered June 27, from noon to 2 p.m., according to the AOA Meetings Center.

At least 28 AOA Navigating with EHR courses, including multiple courses offered at one event, will be offered at optometric meetings around the nation during 2012, according to AOA-CPAG.

"Turnout in the half dozen states (Georgia, Louisiana, Michigan, Oregon, Rhode Island, and South Carolina) where courses have already been offered this year has been substantial," observed AOA Health Information Technology Subcommittee Chair Philip Gross, O.D.

Building on the AOA-CPAG's highly successful program of EHR continuing education courses at Optometry's Meeting® and state optometric association meetings last year, the new "Navigating Meaningful Use, Quality Reporting, and e-Prescribing with EHRs" initiative will this year offer a selection of three two-hour classes designed to provide the specific health information technology (HIT) guidance practitioners need, whether they are just now planning to initiate EHRs in the offices, implementing basic HIT functions such as e-prescribing, hoping to earn substantial Medicare or Medicaid incentive payments by meeting government standards for the "meaningful use" of EHRs, or planning to use HIT to facilitate participation in Medicare's Physician Quality Reporting System (PQRS).

- "EHR Software Selection and Implementation" is an entry-level HIT course for optometrists who plan to implement EHR technology in the coming months.
- "EHR Incentive Programs and Meaningful Use Update" is a more advanced course for practitioners who have already implemented EHRs and are now preparing to take part in the Medicare or Medicaid EHR incentive program.
- "Physician Quality Reporting System (PQRS) and e-Prescribing Made Easy" explains how EHR systems can facilitate participation on the Medicare PQRS or other quality reporting programs.

The "EHR Incentive Programs and Meaningful Use Update" and "Physician Quality Reporting System (PQRS) and e-Prescribing Made Easy" courses will be offered at Optometry's Meeting®.

Optometrists should check with their respective state optometric associations to find out which "Navigating with EHR" courses will be offered during their meetings.

Demonstrations of EHR systems will be offered by leading software vendors following the courses at Optometry's Meeting®.

Like last year's popular "Enhancing Patient Care through the Implementation of EHRs" CE courses, the AOA's new "Navigating Meaningful Use," "Quality Reporting," and "e-Prescribing with EHRs" courses will be presented by a roster of nationally recognized experts on EHR implementation in optometric practice. All three of the lectures are COPE-approved.

The "Navigating Meaningful Use," "Quality Reporting," and "e-Prescribing with EHRs" courses have been developed as part of the "AOA EHR Preparedness Program for Optometry," sponsored by Codex Techworks, Compulink, Eyefinity, First Insight, FoxFire Systems Group, Kowa, Marco, Practice Director (a division of the Williams Group), QuikEyes, and RevolutionEHR.

For additional information and course updates, see the AOA website EHR page (*www.aoa.org/EHR*).

Navigating Meaningful Use, Quality Reporting, and e-Prescribing with EHRs

AOA affiliate	EHR course date
South Dakota	April 12, 2012
New Mexico	April 21, 2012
Kansas	April 26-27, 2012
Ohio	May 2, 2012
Montana	May 3, 2012
Alabama	May 5, 2012
Tennessee	May 5, 2012
New Hampshire	May 9, 2012
Pennsylvania	May 18, 2012
Indiana	July 11, 2012

Index,

from page 10

the 4.1 percent increase in 2010) and a 0.1 percent increase in the cost of non-prescription drugs (which decreased 1 percent in 2010).

It is important to note that eye care-related costs tend to change at various rates around the nation, the BLS emphasized.

The BLS Eyeglasses and Eye Care Services Index is based on approximately 680 quotes for services provided by opticians, optometrists, and ophthalmologists.

They include eye exams, dispensing of eyeglasses and contact lenses, office visits, and surgical procedures performed in a health care practice or hospital. Statistics cited are percentage increases in the indices (U.S. city averages, all urban consumers) from December 2010 to December 2011, not seasonally adjusted.

Price index data for eyewear and eye care, various other segments of health care, and the economy overall – including breakouts by city, region and market size – can be found on the Bureau of Labor Statistics Data website (*http://data.bls.gov/PDQ/outside.jsp?survey=cu*).

Table 1: Eyeglasses and Eye Care Services Indices by year

1987 – 5.3 percent
1988 – 4.7 percent
1989 – 3.4 percent
1990 - 4.5 percent
1991 – 3.6 percent
1992 – 3.7 percent
1993 - 2 percent
1994 – 3.3 percent
1995 – 2.4 percent
1996 – 1.2 percent
1997 – 1.6 percent
1998 – 1.8 percent
1999 – 3.1 percent
2000 – 2.4 percent
2001 – 2.8 percent
2002 – –0.3 percent (decrease)
2003 – 1.5 percent
2004 – 2.9 percent
2005 – 3.1 percent
2006 – 2.0 percent
2007 – 1.5 percent
2008 – 0.3 percent
2009 – 1.7 percent
2010 – 0.3 percent
2011 – 0.7 percent



Optometry's Meeting® a chance for students to be entertained, get career-building help

By Ashley Scantling, O.D., chair of the Student Program Committee

Optometry's Meeting®, June 27 – July 1, 2012, in Chicago, Ill., is the premier event in the ophthalmic industry, merging the meetings for the AOA and the American Optometric Student Association (AOSA). This meeting is not only fun for students every year, but it is of great importance for students professionally. It won't be long before students will be venturing out into practice. Optometry's Meeting® is a great place for students to get a jumpstart on their careers.

Optometry's Meeting® is an excellent place to meet people who may provide significant help in the future. These people could be ODs, vendors or other students; the possibilities are endless. I have met many people at this meeting over the years who have enhanced my career. I encourage each and every student to take full advantage of the vast networking potential this meeting has to offer.

A key reason the student program at Optometry's Meeting® is so successful is that it is designed for students by students. When developing the student education program, we keep in mind that students spend most of the year in the classroom being "lectured at." The goal of the 2012 Optometry's Meeting® Student Program Committee was to put students in a learning environment different from what they get all year in optometry school.

The student education program primarily focuses on practice management – an element that is not often offered in the classroom setting, but is very important as students enter their careers.

Thanks to the generous support of unrestricted education grants provided by The Vision Care Institute™, LLC and TLC Vision, there is no charge for students to take courses offered on the student program.

Be sure to take advantage of this opportunity! As always, students are invited to take most OD and paraoptometric courses at a reduced rate of $5 per credit hour.

Student lecture door prizes are once again generously sponsored by HOYA.

The Exhibit Hall offers a great opportunity for students to start building vendor relationships. Optometry's Meeting® attendees will enter the Exhibit Hall through AOA Central. AOA Central will be the hub of activity – it will house registration and the various entities of the AOA. Here you can learn about the AOA benefits provided to AOSA members. The Student New and New Graduate kiosk and the AOSA kiosk will be of particular interest to students. As you leave AOA Central and enter the Exhibit Hall, be sure to stop by the *Optometry Students.com* booth.

Sight Quest is a fun, interactive approach for students to navigate the Exhibit Hall and learn about some of our industry partners. Students will be given a game card with questions. The object is to visit the designated booths in the Exhibit Hall and ask the corresponding question. Everyone who completes the challenge will be entered to win American Express gift cards valued from $250 to $1,000! Sight Quest cards will be distributed in the AOSA General Session, so be sure to attend.

It's never too early to start thinking about a residency or a job after graduation.

Optometry's Meeting® has the resources for students to explore opportunities for both on Friday, June 29.

- The Optometric Residency Forum will allow students time to visit with residency directors about individual programs and application procedures. Once again, The Vision Care Institute™, LLC is generously sponsoring lunch for the first 250 students to register.
- Optometry's Career Center® will offer an "open mic" of job opportunities from employers and candidates, a career wall, and more. Questions about life after optometry school will be answered in Pathways – UNPLUGGED, an interactive class to help students begin planning their transition from optometric student to physician. Optometry's Career Center® is co-supported by Marchon and Optos.

Students are exposed to a wealth of education, industry connections, and networking opportunities at Optometry's Meeting®. But what would a trip to the "Windy City" be without some fun? Release some stress at these great events:

- Students will be entertained and amazed by the mind-reading abilities of Robert Channing at the AOSA General Session. Thanks to HOYA, the student program kicks off on Thursday afternoon, June 28, with this mind-boggling performance. Students are guaranteed to leave in awe asking, "How did he know that?
- The excitement and tradition of the ever-popular Varilux® Optometry Student Bowl™ and Reception continues in Chicago. The energy at the Student Bowl™ is electrifying and starts before the event as classmates gather in the foyer to cheer on their schools in anticipation of a victory. Be a part of the excitement by rooting on your classmates or alma mater. This must-attend event is sponsored by Essilor.
- iConnect with TLC comes alive with entertaining games of blackjack, Texas hold 'em, and roulette on Friday night. If you're not up for trying your luck, then join your peers and dance the night away with one of Chicago's most renowned DJs. Students who attend the TLC lecture on Friday afternoon, and their registered guests, are invited to this popular event.

Optometry's Meeting® is a great value for students. The nominal registration fee includes the main Optometry's Meeting® events such as the Optometry's Meeting® Welcome Hour, co-supported by the AOA and CooperVision; the Opening General Session, sponsored by Essilor; Exhibit Hall events; and A Celebration of Optometry (Presidential Celebration) at the Field Museum, sponsored by HOYA.

Events such as these, while fun in nature, are a great opportunity for students to network with their peers, ODs, and future business contacts. One of these events could be where you meet your future employer or business partner!

Optometry's Meeting® is the meeting you can't afford to miss! The AOA, Allergan, Essilor, HOYA, and The Vision Care Institute™, LLC, understand this and have collectively supported more than $100,000 in travel grants and scholarships to ensure students who want to attend can attend! Talk to your school trustee to see how you can be one of the lucky recipients.

Visit *www.optometrysmeeting.org* for more information, to register, and to book hotel reservations for the meeting. See you in Chicago!

A key reason the student program at Optometry's Meeting® is so successful is that it is designed for students by students.

Calif., Texas increase privacy requirements

Health care practitioners in Texas and California should review their privacy protection programs to ensure compliance with new laws in those states, according to the AOA Advocacy Group.

Both of the new state laws establish privacy standards stricter than those outlined in the federal Health Insurance Portability and Accountability Act (HIPAA).

Both the California (S.B. 24) and Texas (H.B. 300) legislation expand the range of information protected and the types of businesses covered. Both set down new criteria for the notification of patients in the event of a security breach.

In addition, the Texas law also imposes stiffer penalties for negligent or intentional violations. It also sets the stage for additional privacy protections in the future by directing several governmental and quasi-governmental entities to monitor and report on health care privacy in the state.

The Texas law also establishes several new government task forces on privacy.

The new California privacy law took effect Jan. 1, 2012. The Texas law takes effect Sept. 1, 2012.

The new California privacy law can be accessed online at *http://1.usa.gov/A0e9o2*.

The new Texas privacy law can be accessed online at *http://bit.ly/y4pkCl*.



FIRST-LINE

LUMIGAN® 0.01%

(bimatoprost ophthalmic solution) 0.01%

For patients starting or changing PGA therapy

A drop with low dropout

Efficacy with low overall discontinuation rate:
8.1% (15/186) with LUMIGAN® 0.01%
and 13.4% (25/187) with LUMIGAN® 0.03%[1,2]

Indication: LUMIGAN® 0.01% and 0.03% is indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

Important Safety Information

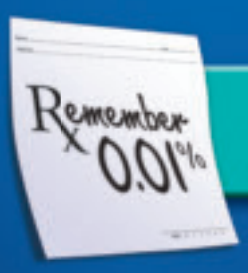
Warnings and Precautions: LUMIGAN® causes changes to pigmented tissues, mostly increased pigmentation of the iris, eyelid, and eyelashes as long as LUMIGAN® is administered. Iris color change may not be noticeable for several months to years. After discontinuation of bimatoprost, iris pigmentation is likely to be permanent, while eyelid and eyelash changes have been reported to be reversible in some patients. Patients should be informed of the possibility of increased pigmentation. The long-term effects of increased pigmentation are not known.

LUMIGAN® should be used with caution in patients with active intraocular inflammation (eg, uveitis) because the inflammation may be exacerbated. Macular edema, including cystoid macular edema, has been reported with LUMIGAN®. LUMIGAN® should be used with caution in aphakic patients, in pseudophakic patients with a torn posterior lens capsule, or in patients with known risk factors for macular edema.

Adverse Reactions: The most common (25%-45%) adverse event with LUMIGAN® was conjunctival hyperemia. Approximately 0.5% to 3% of patients discontinued therapy due to conjunctival hyperemia. Other common events (> 10%) included growth of eyelashes and ocular pruritus.

Please see brief Prescribing Information on adjacent page.

1. LUMIGAN® 0.01% and 0.03% Prescribing Information.
2. Katz LJ et al. *Am J Ophthalmol.* 2010;149(4):661-671.



Prescribe LUMIGAN® 0.01%

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PBA to host 'Focus on Eye Health' national summit

Prevent Blindness America will host "Focus on Eye Health: A National Summit" in Washington, D.C., on June 20 to serve as a key launching pad for newly revised public health data on vision and eye health.

The event will provide updates of two very significant public health reports from PBA – "Vision Problems in the U.S." and the "Economic Impact of Vision Problems," as well as a variety of public health presentations that will address vision and eye health in the United States.

The leading causes of vision impairment and blindness in the United States are primarily age-related eye diseases.

The number of Americans at risk for age-related eye diseases is increasing as the baby boomer generation ages.

These sight-threatening conditions include age-related macular degeneration, cataract, diabetic retinopathy, and glaucoma.

As if the health impact were not enough, blindness and vision impairment represent a significant financial burden to individuals and society.

Despite alarming rates of prevalence and cost, and the lack of understanding of eye disease and preventive behavior, the public resources for vision and eye health prevention, research, and care have also diminished.

This past year alone, the Centers for Disease Control and Prevention (CDC) saw a drastic reduction in funding dedicated to national vision and eye health efforts with a drop from an already low $3.2 million to an alarming $511,000.

Scheduled summit presentation topics include:

- Vision Problems in the U.S: Prevalence of Vision Problems – David Friedman, M.D., Ph.D., MPH, Johns Hopkins University
- Economic Impact of Vision Problems – Kevin Frick, Ph.D., Johns Hopkins University
- National Plan for Eye and Vision Research – Rick Fisher, Ph.D., National Eye Institute
- Surveillance of Vision Problems – Paul Lee, M.D., J.D., University of Michigan
- Co-Morbidities and Vision – John Crews, DPA, Vision Health Initiative, CDC
- Diabetes and the Eye – Ann Albright, Ph.D., RD, Division of Diabetes Translation, CDC

Current gold-level sponsors include the Allergan Foundation, American Academy of Ophthalmology, Transitions Optical, The Vision Council and VSP.

Silver-level sponsors include the AOA, Alliance for Eye and Vision Research, AMD Alliance International, American Foundation for the Blind, Foundation for Eye Health Awareness, Helen Keller International, Lions Club International, Research to Prevent Blindness, ThromboGenics, Vision 2020 USA and VisionServe Alliance.

For more information about the Prevent Blindness America "Focus on Eye Health: A National Summit" or to learn how to become a sponsor, visit *www.preventblindness. org/eyesummit* or call 800-331-2020.

LUMIGAN® 0.01% AND 0.03%
(bimatoprost ophthalmic solution)

INDICATIONS AND USAGE
LUMIGAN® 0.01% and 0.03% (bimatoprost ophthalmic solution) is indicated for the reduction of elevated intraocular pressure in patients with open angle glaucoma or ocular hypertension.

CONTRAINDICATIONS
None

WARNINGS AND PRECAUTIONS
Pigmentation: Bimatoprost ophthalmic solution has been reported to cause changes to pigmented tissues. The most frequently reported changes have been increased pigmentation of the iris, periorbital tissue (eyelid), and eyelashes. Pigmentation is expected to increase as long as bimatoprost is administered. The pigmentation change is due to increased melanin content in the melanocytes rather than to an increase in the number of melanocytes. After discontinuation of bimatoprost, pigmentation of the iris is likely to be permanent, while pigmentation of the periorbital tissue and eyelash changes have been reported to be reversible in some patients. Patients who receive treatment should be informed of the possibility of increased pigmentation. The long-term effects of increased pigmentation are not known.

Iris color change may not be noticeable for several months to years. Typically, the brown pigmentation around the pupil spreads concentrically towards the periphery of the iris and the entire iris or parts of the iris become more brownish. Neither nevi nor freckles of the iris appear to be affected by treatment. While treatment with **LUMIGAN®** 0.01% and 0.03% (bimatoprost ophthalmic solution) can be continued in patients who develop noticeably increased iris pigmentation, these patients should be examined regularly.

Eyelash Changes: LUMIGAN® 0.01% and 0.03% may gradually change eyelashes and vellus hair in the treated eye. These changes include increased length, thickness, and number of lashes. Eyelash changes are usually reversible upon discontinuation of treatment.

Intraocular Inflammation: LUMIGAN® 0.01% and 0.03% should be used with caution in patients with active intraocular inflammation (eg, uveitis) because the inflammation may be exacerbated.

Macular Edema: Macular edema, including cystoid macular edema, has been reported during treatment with bimatoprost ophthalmic solution. **LUMIGAN®** 0.01% and 0.03% should be used with caution in aphakic patients, in pseudophakic patients with a torn posterior lens capsule, or in patients with known risk factors for macular edema.

Angle-closure, Inflammatory, or Neovascular Glaucoma: LUMIGAN® 0.01% and 0.03% has not been evaluated for the treatment of angle-closure, inflammatory, or neovascular glaucoma.

Bacterial Keratitis: There have been reports of bacterial keratitis associated with the use of multiple-dose containers of topical ophthalmic products. These containers had been inadvertently contaminated by patients who, in most cases, had a concurrent corneal disease or a disruption of the ocular epithelial surface.

Use With Contact Lenses: Contact lenses should be removed prior to instillation of **LUMIGAN®** 0.01% and 0.03% and may be reinserted 15 minutes following its administration.

ADVERSE REACTIONS
Clinical Studies Experience: Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice.

In clinical studies with bimatoprost ophthalmic solutions (0.01% or 0.03%), the most common adverse event was conjunctival hyperemia (range 25%-45%). Approximately 0.5% to 3% of patients discontinued therapy due to conjunctival hyperemia with 0.01% or 0.03% bimatoprost ophthalmic solutions. Other common events (> 10%) included growth of eyelashes and ocular pruritus.

Additional ocular adverse events (reported in 1% to 10% of patients) with bimatoprost ophthalmic solutions included ocular dryness, visual disturbance, ocular burning, foreign body sensation, eye pain, pigmentation of the periocular skin, blepharitis, cataract, superficial punctate keratitis, eyelid erythema, ocular irritation, eyelash darkening, eye discharge, tearing, photophobia, allergic conjunctivitis, asthenopia, increases in iris pigmentation, conjunctival edema, conjunctival hemorrhage, and abnormal hair growth. Intraocular inflammation, reported as iritis, was reported in less than 1% of patients.

Systemic adverse events reported in approximately 10% of patients with bimatoprost ophthalmic solutions were infections (primarily colds and upper respiratory tract infections). Other systemic adverse events (reported in 1% to 5% of patients) included headaches, abnormal liver function tests, and asthenia.

USE IN SPECIFIC POPULATIONS
Pregnancy: Pregnancy Category C.

Teratogenic effects: In embryo/fetal developmental studies in pregnant mice and rats, abortion was observed at oral doses of bimatoprost that achieved at least 33 or 97 times, respectively, the maximum intended human exposure based on blood AUC levels.

At doses at least 41 times the maximum intended human exposure based on blood AUC levels, the gestation length was reduced in the dams, the incidence of dead fetuses, late resorptions, peri- and postnatal pup mortality was increased, and pup body weights were reduced.

There are no adequate and well-controlled studies of **LUMIGAN®** 0.01% and 0.03% (bimatoprost ophthalmic solution) administration in pregnant women. Because animal reproductive studies are not always predictive of human response, **LUMIGAN®** should be administered during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether **LUMIGAN®** 0.01% and 0.03% is excreted in human milk, although in animal studies, bimatoprost has been shown to be excreted in breast milk. Because many drugs are excreted in human milk, caution should be exercised when **LUMIGAN®** is administered to a nursing woman.

Pediatric Use: Use in pediatric patients below the age of 16 years is not recommended because of potential safety concerns related to increased pigmentation following long-term chronic use.

Geriatric Use: No overall clinical differences in safety or effectiveness have been observed between elderly and other adult patients.

Hepatic Impairment: In patients with a history of liver disease or abnormal ALT, AST, and/or bilirubin at baseline, bimatoprost 0.03% had no adverse effect on liver function over 48 months.

OVERDOSAGE
No information is available on overdosage in humans. If overdose with **LUMIGAN®** 0.01% and 0.03% (bimatoprost ophthalmic solution) occurs, treatment should be symptomatic.

In oral (by gavage) mouse and rat studies, doses up to 100 mg/kg/day did not produce any toxicity. This dose expressed as mg/m^2 is at least 70 times higher than the accidental dose of one bottle of **LUMIGAN®** 0.03% for a 10-kg child.

NONCLINICAL TOXICOLOGY
Carcinogenesis, Mutagenesis, Impairment of Fertility: Bimatoprost was not carcinogenic in either mice or rats when administered by oral gavage at doses of up to 2 mg/kg/day and 1 mg/kg/day respectively (at least 192 and 291 times the recommended human exposure based on blood AUC levels respectively) for 104 weeks.

Bimatoprost was not mutagenic or clastogenic in the Ames test, in the mouse lymphoma test, or in the *in vivo* mouse micronucleus tests.

Bimatoprost did not impair fertility in male or female rats up to doses of 0.6 mg/kg/day (at least 103 times the recommended human exposure based on blood AUC levels).

PATIENT COUNSELING INFORMATION
Potential for Pigmentation: Patients should be advised about the potential for increased brown pigmentation of the iris, which may be permanent. Patients should also be informed about the possibility of eyelid skin darkening, which may be reversible after discontinuation of **LUMIGAN®** 0.01% and 0.03% (bimatoprost ophthalmic solution).

Potential for Eyelash Changes: Patients should also be informed of the possibility of eyelash and vellus hair changes in the treated eye during treatment with **LUMIGAN®** 0.01% and 0.03%. These changes may result in a disparity between eyes in length, thickness, pigmentation, number of eyelashes or vellus hairs, and/or direction of eyelash growth. Eyelash changes are usually reversible upon discontinuation of treatment.

Handling the Container: Patients should be instructed to avoid allowing the tip of the dispensing container to contact the eye, surrounding structures, fingers, or any other surface in order to avoid contamination of the solution by common bacteria known to cause ocular infections. Serious damage to the eye and subsequent loss of vision may result from using contaminated solutions.

When to Seek Physician Advice: Patients should also be advised that if they develop an intercurrent ocular condition (e.g., trauma or infection), have ocular surgery, or develop any ocular reactions, particularly conjunctivitis and eyelid reactions, they should immediately seek their physician's advice concerning the continued use of **LUMIGAN®** 0.01% and 0.03%.

Use with Contact Lenses: Patients should be advised that **LUMIGAN®** 0.01% and 0.03% contains benzalkonium chloride, which may be absorbed by soft contact lenses. Contact lenses should be removed prior to instillation of **LUMIGAN®** and may be reinserted 15 minutes following its administration.

Use with Other Ophthalmic Drugs: If more than one topical ophthalmic drug is being used, the drugs should be administered at least five (5) minutes between applications.

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EyeLearn Online Educational Portal

An Exclusive AOA Member Benefit

- Interactive learning modules
  - Flexible – Pause at any point and return to the course on your schedule
  - Course handouts can be viewed or printed
  - Self-assessment quizzes help you focus your study time
  - Repeat a unit to better understand the material
- Access supplemental resources
  - Recorded audio and video lectures at the click of a mouse
  - AOA Optometric Clinical Practice Guidelines assembled in one place
  - Articles from Optometry: Journal of the American Optometric Association grouped by relevant subjects
- Continuing education finder that lists for-credit CE courses (searchable by ZIP code, city, state or topic)

eyelearn
AOA's Online Learning Resource

Check out EyeLearn today @ www.aoa.org/eyelearn!

EyeLearn™ course spotlight

Pediatrics/binocular vision/vision therapy course offers practical approach to children's care

In many respects, children's vision care can be considered one of the fastest-growing and most promising segments of optometry, according to Mitchell Scheiman, O.D., the lecturer for AOA EyeLearn™'s new pediatrics/ binocular vision/vision therapy online continuing education course.

Educators and parents alike appear to increasingly recognize the importance of addressing eye and vision conditions that can lead to academic underachievement or other problems in life, Dr. Scheiman said.

Last year alone, some 12,874 parents brought their children to optometric practices for InfantSEE® examinations.

However, Dr. Scheiman, a professor of optometry and director of the pediatric and binocular vision program at the Pennsylvania College of Optometry, acknowledged many practicing optometrists may still be daunted by the unique challenges encountered in providing care for children.

The EyeLearn™ pediatrics/ binocular vision/ vision therapy course breaks down the basics of children's vision practice in a series of eight concise learning modules, covering the key concepts and components of care – and a number of helpful hints, Dr. Scheiman said.

Like other EyeLearn™ online offerings, the pediatrics/ binocular vision/ vision therapy course was developed, in part, to provide a helpful refresher for optometrists who are preparing to take American Board of Optometry board certification examinations.

However, the course is also intended to provide busy, practicing optometrists a simple, step-by-step approach that can be used to make the diagnosis and care of pediatric eye problems practical in almost any optometric office, Dr. Scheiman said.

The course is also intended to provide busy, practicing optometrists a simple, step-by-step approach that can be used to make the diagnosis and care of pediatric eye problems practical in almost any optometric office.

The course has so far drawn a four-star rating from online students, largely because "the emphasis is on practical skills and knowledge," Dr. Scheiman believes.

"For example, practitioners should first understand the importance of the case history in pediatric care," Dr. Scheiman said.

For that reason, the course opens with a review of the differences between an adult and a pediatric case history, the interview techniques involved in compiling a pediatric history, and the use of surveys and questionnaires to facilitate the process. Guidance on patient – and parent – education is offered.

The course then provides a brief overview of anisometropia in pediatric patients with a detailed look at amblyopia.

Dr. Scheiman then reviews the assessment and differential diagnosis of non-strabismic binocular vision and accommodative disorders, and the treatment and management of those conditions.

Students then move on to consider the assessment and treatment of visual processing disorders.

In a final segment, Dr. Scheiman reviews the assessments and treatment of vision problems resulting from acquired brain injury.

Like all EyeLearn™ courses, the pediatrics/ binocular vision/ vision therapy course is presented in a series of interactive learning modules that allow practitioners to log on and access the learning materials whenever they are ready.

Modules range in length from a mere five minutes to just under a half hour. The entire course can be completed in just under two and a half hours.

The electronic format allows those taking the course to pause at any point and return to the course later. They can immediately repeat a unit if they do not adequately understand the material covered.

Each unit comes with one or more self-assessment quizzes that appear periodically. Course handouts are provided on the EyeLearn™ website. Course takers can even follow the speaker word for word using course transcripts that are also provided on the site.

In addition to interactive learning modules, practitioners can easily access supplemental resources such as AOA Optometric Clinical Practice Guidelines and articles from *Optometry: Journal of the AOA* as well as a range of pre-recorded audio or video lectures.

A Continuing Education (CE) Finder feature allows optometrists to find appropriate classroom continuing education programs on the posterior segment and related subjects, offered by state optometric associations, regional optometric organizations, and the AOA.

The EyeLearn™ online education portal is an exclusive AOA member benefit. AOA members can take courses and access materials free of charge. The optometric education portal can be accessed at *www.aoa.org/eyelearn.*

EyeLearn™ Pediatrics/Binocular Vision/Vision Therapy Board Certification Review Course (143 minutes)

User rating: 4 Stars

Part 1- Pediatric Case History/Interviewing and Patient Education (eight minutes)

Part 2- Anisometropia (five minutes)

Part 3- Amblyopia (25 minutes)

Part 4- Assessment and Differential Diagnosis of Non-Strabismic Binocular Vision and Accommodative Disorders (21 minutes)

Part 5- Treatment and Management of Binocular Vision and Accommodative Disorders (15 minutes)

Part 6- Assessment and Differential Diagnosis of Eye Movement Anomalies (23 minutes)

Part 7- Assessment and Treatment of Visual Processing Disorders (28 minutes)

Part 8- Diagnosis and Treatment of Vision Problems After Acquired Brain Injury (18 minutes)

American Optometric Association
eyelearn™ AOA's Online Learning Resource

What's all the tweeting about?



Here's a taste of what some in the optometric world are talking about on AOAConnect, Twitter and Facebook.

@AOAConnect tweeted: Early eye exam important for kids: *http://www.americanownews.com/story/16963060/early-eye-exam-important-for-kids* # via @AddThis Find an optometrist via the AOA Dr. Locator: *http://www.aoa.org/x5428.xml*

@WorldCouncilOpt retweeted: Dr Pete Kehoe, Past President of the AOA (@AOAConnect), is speaking at WCO's next conference in Chicago. Join us there! *http://bit.ly/woZpPH*

@VisionMonday tweeted: AOA Updates 2012 Optometry's Meeting and Unveils New Logo *http://ow.ly/932Wk* @AOAConnect #optometrysmtng

The AOA posted on its Facebook page: "Jillian's Story," an inspirational true-life account about how optometric vision therapy dramatically changed one young girl's life, is now available for download and loan on Kindle, NOOK, iPad and Sony e-readers. Amazon and Barnes & Noble have lending programs; "Jillian's Story" has been loaning enabled. Kindle or NOOK owners can download "Jillian's Story" to their e-reading device and loan it to someone else for a period of 14 days. Loaned e-books can also be read via free reading applications on PC, Mac, iPad, iPhone, BlackBerry, and Android devices. Take a brief look at "Jillian's Story" in her own words in this video, pictured below (*http://www.youtube.com/watch?v=ky8YGd5_tAI*).

The AOA posted on its Facebook page: Today, Congress approved a compromise measure to prevent enactment of a massive Medicare pay cut aimed at ODs and other physicians. With the immediate threat now averted, many optometrists that bill Medicare will continue to see even higher payments in 2012 as a direct result of AOA's advocacy in the nation's capital.



The AOA via Oklahoma Association of Optometric Physicians posted on its Facebook page: Are you out and about in snow or freezing rain today? While driving through inclement weather, quick reaction times are especially crucial. That's a great reason to call your optometrist today and schedule a comprehensive eye exam. Preventative care is key; don't wait until problems worsen to seek help.



http://dori20-20tour.org/

Pay cut,

from page 6

increase than optometry in 2012.

Of note, no MD specialty will see as much as a 2 percent increase in 2012.

While AOA volunteers and staff will continue working closely with House and Senate leaders in the coming months to find a lasting and equitable solution to Medicare's flawed payment formula and to address the threat of sequester cuts in 2013 and beyond, even more ODs and students are being urged to join the fight for patients and the profession.

Hundreds of AOA doctors and students will be on Capitol Hill to address Medicare pay and other priorities for the profession during the AOA's Super Advocacy Meetings in Washington, D.C., April 1-3 (AOA Congressional Advocacy Conference and AOA State Government and Third Party National Conference).

For information on the upcoming AOA Congressional Advocacy Conference, visit *www.aoa.org/x20634.xml*.

To learn about becoming more involved in federal advocacy, contact the AOA Washington office at 800-365-2219 or *Impact WashingtonDC@aoa.org*.

New ways to connect with AOA...

www.facebook.com/american.optometric.association

www.twitter.com/aoanews

www.youtube.com/aoaweb



American Optometric Association
Member Advantage

Ophthalmic Resources On-Demand

Get quick, easy access to valuable pharmaceutical product resources



Try it free at www.AOA.org/OROD

Foundation calls for nominations for InfantSEE® Sullins award

The AOA Foundation and the InfantSEE® program invite the optometry community to submit nominations for the Dr. W. David Sullins, Jr. InfantSEE® Award.

This award recognizes an individual doctor of optometry who has made significant contributions to optometry or his/her community for outstanding public service involving the InfantSEE® program.

The award will be presented at Optometry's Meeting® in Chicago, Ill., slated for June 27 – July 1, 2012.

The recipient will receive travel reimbursement up to $1,000 and a gold medallion.

To nominate a colleague, visit Optometry Cares® – The AOA Foundation's website at *www.AOAFoundation.org*.

Nominations must be submitted online by April 30, 2012.

If you have questions about the application process, contact the AOA Foundation at *foundation@aoa.org* or at 800-365-2219, ext. 4209.

Minnesota Board 1910



Shown are Hugo Schleuder, H.M. Hitchcock, C.A. Snell, F.J. Pratt, and Albert Myer, who were appointed to the Minnesota Optometry Board. In 1910, there were 390 licensed optometrists in the state. Candidates completed both written and oral exams. They were also required to take a subjective test with trial case equipment, both for refractive errors and muscular imbalances, and to demonstrate skill in the use of the ophthalmometer and the ophthalmoscope. Those seeking registration were expected to demonstrate familiarity with the retinoscope, be able to adjust frames, and to neutralize lenses.
(Photo from the collection of The Archives & Museum of Optometry, Optometry Cares® – The AOA Foundation)

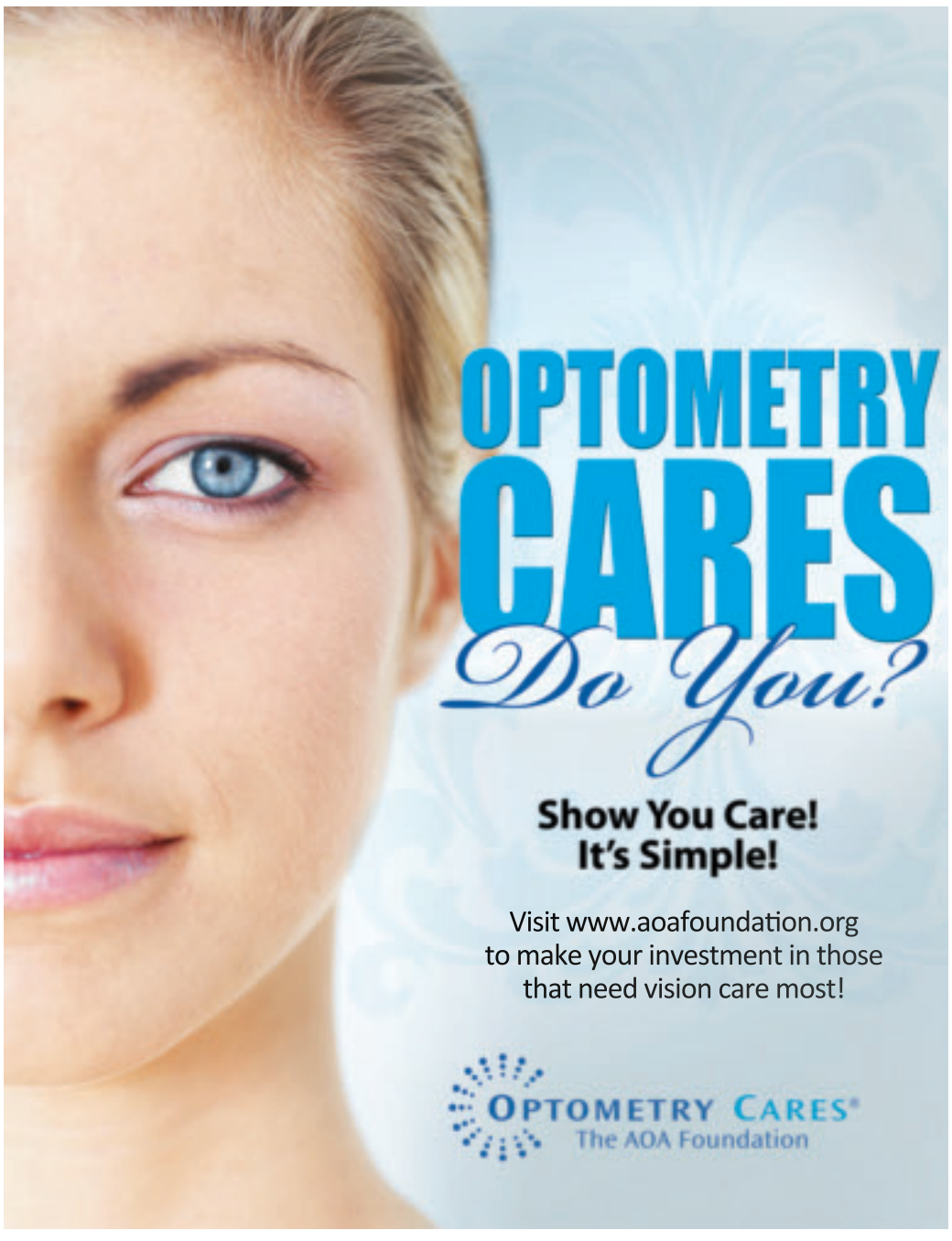
Optometrist Cyrus Bass vs. the AMA

Check out the latest Historical Gem – a short account of a big deal – when a single optometrist took on the mighty American Medical Association in a 1964 lawsuit. This is the last of a three-part series on interprofessional relations by Irving Bennett, O.D. You can read it along with other interesting stories at *www.aoafoundation.org*. This is your history!

Become a VISION USA provider today!

VISION USA, a program of Optometry Cares® – The AOA Foundation, provides basic eye health and vision services free of charge to low-income, uninsured individuals and their families in 39 states. Since its inception in 1991, more than 414,000 Americans have been assigned to an optometrist for an eye exam.

The VISION USA program is grateful to the many providers in communities throughout the United States who volunteer their time and expertise. If you are not yet a VISION USA provider and would like to become one, simply send an email to *visionusa@aoa.org* to enroll.



Multiple factors affect practice valuation process

Sam Quintero, O.D., Practice Advancement Committee

There is no single commonly accepted method for valuing an optometric practice. No two practices are exactly alike. There are relative and extremely variable economic conditions within a community and the amount and type of local competition that affect the value of a practice. The location, decor, tenure, quality of operation, equipment, management systems in place, and financial health will also significantly determine whether or not a practice should even be considered for purchase.

There are two aspects to practice valuation: one is the process of appraising the value of the enterprise, and the other is assessing the economics of the enterprise, considered to be the process of "due diligence" by a prospective buyer.

The first to be considered is appraised value of the enterprise. The basis for valuing a business can be found in Revenue Ruling 59 – 60, issued by the Internal Revenue Service (IRS) and accepted by the American Society of Appraisers, as "the price, in cash or equivalent, that a buyer could reasonably be expected to pay and a seller could reasonably be expected to accept if the property, business or professional practice were exposed for sale on the open market for a reasonable period of time, both buyer and seller being in possession of the pertinent facts, and neither being under compulsion to act."

These very important factors should be kept in mind: the length of time a seller is able to remain to provide a smooth transition affects the purchase significantly; all assets of the optometric practice are valued, including, but not limited to, the ophthalmic equipment, instruments, furnishings, decorator items (only personal items are excluded); all

See Valuation, page 40

AOA Webinar Series
A FREE Member-Only Benefit

ICD-10: Advance Planning for October 1, 2013

Now is the time to create your office's plan for making the transition to ICD-10, including a timetable for training, software updates, purchases of reference materials, etc. This will be the first in a series of quarterly webinars to update on this important topic.

Tuesday, March 27th 11a.m. CST

ICD-10: Advance Preparation for New Diagnosis Coding

Join us for this free event to discuss 6 tell-tale signs that a billing department is in need of an overhaul. Register today to learn how you can help build more efficiency, increase productivity, improve reimbursement flow, and ensure the most successful 2012 possible.

Thursday, March 29th 11a.m. CST

Register Today!
www.aoa.org/WebinarSeries
www.aoa.org/ArchivedWebinars

AOA Member Advantage

Bank of America offers tips on taking care of personal information

Take care of your personal information

You are the single best person to protect your personal information because only you can control what information you share.

Protecting this information is the first step in reducing your risk of identity theft and fraud.

Here are some tips for keeping your information secure:

❖ Carry only necessary identification and cards with you. Don't carry your Social Security card.

❖ Retrieve incoming mail from your mailbox quickly. Do not leave outgoing mail in a mailbox or unsecured location.

❖ Make copies of all the financial information you carry with you daily and store the copies in a safe place.

❖ Never provide personal information unless you initiated the contact and have confirmed the business or person's identity.

Reduce your paper trail

One very easy way to protect your personal information is to limit the amount of paper that has your personal information printed on it.

Criminals can get these documents by stealing your mail or even your trash.

Here are some ways you can eliminate unnecessary paper and increase your security:

❖ Shred unnecessary financial documents immediately before throwing them away.

❖ Stop receiving paper account statements and bills in the mail. Instead, use an online banking or bill pay service.

❖ Stop receiving your canceled checks and sign up for direct deposit to have funds put directly in your account without the need for paper checks.

❖ Opt-out of pre-approved credit card offers by dialing 888-567-8688. This will communicate your preference to all three of the major credit bureaus.

Here are some things to remember:

❖ Share personal information only with trusted sources.

❖ Avoid transactions with companies or individuals whose identities you can't verify.

❖ When shopping online, use only reputable merchants and look for security indicators on your browser window.

Call Bank of America Credit Card at 800-932-2775 to learn more and ask about the AOA member benefit.

American Optometric Association
Member Advantage

www.aoa.org/MemberAdvantage

AOA Group Insurance by AGIA
AOA Insurance Alliance by Lockton (Malpractice Insurance)
AOA Coding Today
AOA Ophthalmic Resources On-Demand
Bank of America Card Services
Bank of America Merchant Services
EyeCarePro
Members' Retirement by AXA-Equitable
OMG National
ReimbusementPLUS®
United Parcel Service, Inc.
VisionWeb
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Through a network of suppliers, Member Advantage provides savings on valuable business, finance and insurance products and services for your practice.

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'Ask the Codeheads'

Time to audit your own medical record-keeping: Concentrate on first and second party in order to prepare for third party

Edited by Chuck Brownlow, O.D., Medical Records consultant

Much has been done recently to assist providers in their relationships with insurers, the third parties of health care. Current Procedural Terminology and the Documentation Guidelines provide step-by-step guidance for accurately choosing codes to represent the services provided. The AOA offers many valuable resources to assist members in keeping good medical records and for understanding the rules related to record-keeping. Websites for Medicare and other insurers permit doctors and staff to learn rules unique to each payer.

In spite of an abundance of information, there is still a lot of confusion among providers regarding how and when care can be provided, and how and whether the care will be paid for.

Sometimes it may seem that the third party, the patient's insurer, has more to say about the care provided than the first and second party, the patient and the doctor/staff.

This confusion should provide an opportunity for a fresh look at how care is provided in your office.

It's time to go back to basics to be sure all care is driven by the needs of the patient and by the doctor's search for information to assist in diagnosing and managing the patient.

Some of what we hear and read seems to run counter to this basic logic.

An insurer may pay for visual fields twice a year, yet a specific patient clearly requires a third visual field within that time period.

An insurer may authorize payment for imaging only if the patient's diagnosis can be found on the insurer's list of diagnoses for which the service is paid.

The doctor's electronic health record might make it very easy to record a lot of data, even though the patient's needs at a given visit are very straightforward, actually requiring very little data.

An equipment manufacturer's representative might explain the new instrument will "pay for itself" if used just five times each day, though the doctor may only require the information provided by the instrument once or twice per week.

A colleague may proudly state that she/he has seen a significant increase in revenue since learning that several common diagnosis codes will assure insurance company payments for tests that used to be fairly uncommon in the doctor's practice.

With all the conflicting information and advice swirling around today's provider, it may be beneficial to adjust one's focus, to simplify one's approach.

This is a good time to return to the roots of health care and to focus again purely on the unique needs of each patient.

The delivery of care for every patient should be done as consistently as possible and to the extent necessary without consideration of fees to be generated, equipment to be justified, or even the rules of the patient's insurer.

All of those considerations should be secondary or tertiary, never primary, considered after the needs of the patient are dealt with.

With that in mind, consider the following caveats for the delivery of health care in 2012:

❖ Carefully interview the patient to learn why he or she has come to the office today: the reason for the visit

❖ Customize the case history to learn as much as possible about the reason, focusing on the elements of the patient's general health history, past and present, family history, and social history that are pertinent to the needs of the patient, adjusting the reason and the components of the case history as you learn more

❖ Customize the elements of the physical examination to discover diagnoses related to the patient's reason for visit and to establish the basis for managing the patient's conditions, including only tests that are germane to the reason for visit

❖ Determine the definitive diagnosis and/or rule out diagnoses related to the day's visit

❖ Choose procedure and diagnosis codes for reporting the care to the patient and/or the patient's insurer based purely upon the content of the record for the day

It's time to go back to basics to be sure all care is driven by the needs of the patient and by the doctor's search for information to assist in diagnosing and managing the patient.

See Codeheads, page 40

AOA Coding Resources

The following resources are available to AOA members through the AOA's Clinical & Practice Advancement Group:

❖ AOA.org/Coding features a "Frequently Asked Questions" section for members only, providing questions asked by AOA members and the answers provided by AOA volunteers and staff.

❖ AskTheCodingExperts@AOA.org offers AOA members the opportunity to e-mail their coding question and have it answered by an AOA staff or volunteer who is very knowledgeable in medical records and coding.

❖ AOA Coding Webinars are provided as an AOA member-only benefit to educate doctors and staff on medical recording keeping and coding.

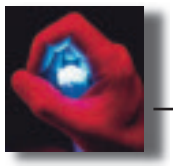
❖ AOAConnect is a social networking site and features a Coding & Billing Group where AOA members, students, volunteers and staff can share information that specifically relates to coding and billing (*connect.aoa.org*).

❖ AOACodingToday.com is an AOA member-only benefit available to all AOA members at no cost (previously $349). CodingToday.com is a Web-based resource for information related to procedure and diagnosis codes, national and local coverage rules, and Medicare relative value information.

❖ AOA.ReimbursementPlus.com Suite, a customized version of the industry-leading CPT Data & Information Service, ReimbursementPlus® is the leading cloud-based service for any information related to procedure and diagnosis codes, fee analysis, CMS reimbursements, national and located coverage rules, CCI edits and any other CPT information desired, all specific to the practitioner's ZIP code. *AOA.ReimbursementPlus.com* provides critical real-time information that will greatly benefit AOA members in medical coding and compliance within their eye care practices.

❖ Codes for Optometry is provided by the AOA's Order Department for $135. It is a two-volume set including Current Procedural Terminology© American Medical Associaiton codes and a separate volume of diagnosis codes used in eye care, Medicare's Correct Coding Initiative, the HCPCS codes for reporting materials in Medicare, and the Documentation Guidelines for the Evaluation and Management Services. Codes for Optometry is available on a CD in a searchable format.

AOA volunteers and staff have always been devoted to assisting members in dealing with the challenges of everyday practice life, including those related to insurance programs. The AOA is excited to bring this expertise directly to members' offices as a value-added member beneift. Much of these benefits are provided at no cost or at greatly reduced cost to AOA members.



Heads up! Latest in Google HUD glasses technology set to hit market by end of year

By Dominick M. Maino, O.D., and Geoffrey G. Goodfellow, O.D.

Google plans to release a heads-up display (HUD) system to be worn like a pair of glasses or goggles (Google Glasses). More than likely this device will be integrated with not only the expected camera, but also voice search, local search, and optical character reading technology.

This consumer technology will supposedly include Google Cloud connectivity, a global positioning system, motion sensors, and 3G/4G connectivity, as well as a map overlay capability that will allow you to follow a HUD to the location you seek telling you the number of miles to go and when to turn.

This device could possibly allow you to find lost children in a store, friends at a concert and, more important, your lost car in the mall parking lot when you do not remember where you parked it.

Recording your life second by second, picture by picture and video by video may be as easy as blinking with the built-in camera.

As Google now owns Zagat, you will probably also receive instant reviews to the restaurant you just walked by as well.

Until the device hits the market, however, all of this is somewhat speculative.

These glasses are supposed to be ready for the public by the end of the year and may cost up to $600 (not including refraction!).

According to one report (*www.9to5google.com*) the glasses will mimic Oakley Thumps, high-tech sunglasses that also act as wireless headphones.

The HUD unfortunately is to be placed on one lens, and because it is non-transparent, 3-D images cannot be projected.

The glasses are controlled by tilting the head to scroll and then clicking.

These glasses are not necessarily to be worn constantly, just when needed. They are to be used the way we use our smartphones.

Several issues need to be addressed of course.

One of those issues is privacy. Do you really want to be recorded every time you speak to your best friend? Probably not.

For optometrists, there are also issues regarding providing refractive care, including the possible need for a plus add for those 40 or older. Because one side of the glasses will have the non-transparent HUD, problems related to binocularity come into play, as well as visual field and mobility. Did we mention that driving a car while wearing these spectacles may even be more hazardous than texting and driving?

More on HUDs

Motion Research Corporation showcased its consumer heads-up display for motorcycle and bicycle helmets at the Annual Cycle World International Motorcycle Show.

When using this HUD, users can access their speed, distance, location and other information that is supposed to enhance their performance and safety.



The "Google Glasses" are reported to have a similar appearance to Oakley Thumps, shown here.

So far, these various HUDs have been used in Formula 1 and Indy car racing, on motorcycles, bicycles and even go-karts.

During the 2012 Consumer Electronics Show, a heads-up display for the driver was shown.

This HUD device sits where one would normally expect to see the auto's rear-view mirror (not sure what they expect to do with the mirror, which you will still need).

The laser display connects by Bluetooth to a special app on your smartphone and can display directions, points of interest, and hazards on the road.

The HUD images are projected on a see-through display sitting on top of your road view, but do not obscure your view while driving.

It seems to us that Google and all creators of HUDs need to contact the AOA for immediate expert guidance from our colleagues to minimize consumer danger so that manufacturers can maximize consumer enjoyment.

As the population of the United States ages, concerns about accommodative demand, binocularity and eye health become vitally important and the role of the primary eye and vision care optometrist significant.

AOA Order Dept. features See Better, Play Better prints



"See Better, Play Better" is the theme of the latest series of AOA Brand Promise four-color art prints to be offered by the AOA Order Department.

Suitable for display in optometric practices and other settings, the seven new 20" by 24" canvas prints – designed to remind patients of the importance of vision in sports performance – depict scenes of baseball, golf, soccer, and hockey.

The Brand Promise series now offers a total of 40 high-quality art prints with themes ranging from children's vision to eye care for older adults.

All prints come ready to hang with hardware included and no framing required.

Prints are $89 for AOA members and $133.50 for non-AOA members (plus shipping and tax where applicable).

Prints can be viewed on the AOA Brand Promise website at *www.aoabrandpromise.com*.

To order call the AOA Order Department at 800-262-2210 or log onto *www.aoa.org/onlinestore*.

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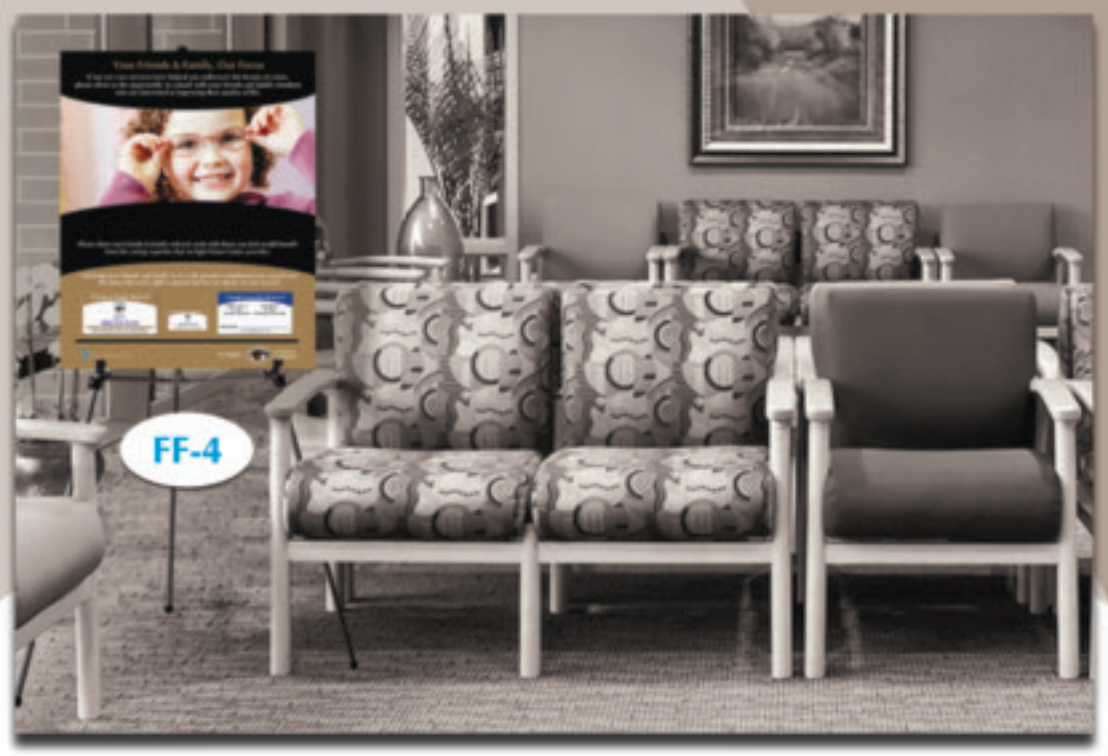
front & back

Referral Cards
(included with each kit)

Thank You Cards (sold separately)



front & back (blank inside)



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Call the AOA Marketplace at 800-262-2210, visit www.aoapracticegrowth.com or scan this QR Code with your mobile phone.



PRACTICE STRATEGIES

Check out Practice Strategies, a popular section of Optometry, now in the AOA News, with expanded content and timely resources.

The practice management consultant

Think about exceeding – not just meeting – expectations

By Gary Gerber, O.D.

Think of the five-star hotel, where guests open the door to their room to find a basket of fresh fruit or recently baked cookies waiting for them. Or the fine women's boutique, where a helpful concierge warmly greets patrons when they arrive. Or a deluxe automobile dealer, where the customer's car is not only serviced, but washed.

Customers leave impressed whenever they get more than they bargained for. When a service provider doesn't simply meet but exceeds customer expectations, not only do people come back, but they can't wait to tell others.

At a time when a "C" is viewed as a more-than-passable grade, scoring an "A" is greatly valued and exceedingly rare.

This philosophy of trying to offer more than expected can and should be something all service providers strive for, including optometry practices. Unfortunately, few practitioners think that way. Rather, most set the bar far lower, content in making sure patients get to see the doctor before they start complaining, are not misdiagnosed, and leave with glasses or contact lenses that allow them both to see and don't hurt.

In normal times, providing an acceptable, dependable service usually works – if for no other reason than it's as good if not better than what the competition offers. Yet, it doesn't cut it during difficult economic times. Today, the opportunity to save a few dollars, find a doctor who is closer to home, or the decision to move from practice to practice due to the vagaries of one's present insurance plan often trumps patient loyalty.

However, when the experience of visiting an eye care practice is particularly memorable, people will do everything possible to keep from switching. Or, if they do leave, they often return once they realize the quality of service in the practice is not easily duplicated. Not only that, they can't wait to brag about the service to others.

It's that rare time when all other factors – convenience, practicality, economics – take a backseat to the patient's realization that this experience is special.

What can an eye care practitioner do to create that special feeling? The first step in exceeding your patients' expectations begins with knowing their expectations. How do you find out? You ask them. For example, if patients say they expect their doctor to be someone they can depend on for their vision needs, it may be as simple as routinely calling patients a couple of days after they've bought a new pair of contact lenses or eyeglasses to see how they like them, or contacting them after a procedure they had with the ophthalmologist you referred them to, to see how they're feeling.

If you find young mothers feel stressed about finding babysitters in the middle of the day when they have doctors appointments, a child-friendly waiting room with climbing gear, computers and coloring books, or a special time set aside on certain days in the office for a staff member to watch young children might go a long way to exceeding their expectations.

So may offering snacks or creating waiting rooms that keep adult patients happily content. As an example, one optometrist specializing in sports vision training built a putting course to give patients, many of whom are golf aficionados, something better to do than read month-old magazines.

Generally speaking, patients expect their doctors to stand behind their products. That's why they expect that if the new frames they just bought break, they will be fixed without any hassles.

However, the practice that agrees, with a smile, to fix patients' frames, regardless of the reason they broke and whenever they were purchased, surpasses expectations. Refund and warranty policies should not be allowed to get in the way.

No one expects any service to be perfect all the time, but those organizations that exceed expectations even manage to leave a positive impression when things go wrong.

Consider the restaurant that when hearing from the customer that the steak was cooked too well done doesn't just present the customer with a new steak prepared to specifications, but also makes sure the potatoes and vegetables have been warmed and sends over a free glass of wine.

That's how every eye care practice, much less every business, should think – particularly at a time when going the extra distance has never been more important.

(Gary Gerber, O.D., is the president and founder of The Power Practice®, a practice management consulting company. He can be reached at drgerber@powerpractice.com *or 800-867-9303 [*www.facebook.com/ThePowerPractice *and Twitter @PowerYour Dream]).*

The bottom line

Transferring ownership of an optometric practice

By James R. Armstrong, CPA, and Jodi Permenter, CPA

Finally made the decision to buy or sell a practice? Don't enter into an agreement without giving consideration to exactly how this will be done. The structure of a transaction may affect the sales price the seller receives, the income tax liability on the sale, and future liabilities associated with the business.

Similarly, for those looking to establish or expand their practice through the purchase of a pre-existing entity, the structure of the sale will influence the bottom line for years to come. It may seem like a simple transaction, but the sale of a practice has far-reaching effects.

The methods of practice sale differ according to the type of business entity and the state in which it was formed.

A sole proprietorship or other single-member entity can be transferred with a simple agreement between the buyer and seller.

Entities with multiple members or partners may require the approval of the sale by the remaining partners.

The way in which the ownership of a practice is transferred cannot only affect the price of the practice but have important tax implications.

Partnerships and multi-member limited liability corporations (LLCs) can be further complicated because, depending on state law, the entity may automatically dissolve upon the withdrawal of a partner.

In order to prevent problems when a partner does wish to retire or sell a portion of the partnership, it is important for partners to sign an agreement dictating how a sale of a partnership interest must be executed.

Generally, a partnership agreement, operating agreement, or a buy-sell agreement should be included in the organizational documents of the entity.

There are two general ways to structure the sale of a business: a sale of assets or a sale of stock/ownership interest.

While there are benefits and drawbacks to each, sellers generally prefer to execute a direct stock sale, while buyers find a direct asset sale more advantageous.

It is important to understand the point of view of both parties in the sale, as it can have a large impact on selling price and negotiations, as well as the future cash-flow of the transaction.

A stock sale occurs when a buyer purchases an ownership interest in the company itself.

see Ownership, page 41



Sun knows no season: sizzling sunwear sales

By Joan V. Abney, manager, Paraoptometric Section

A patient walks through your office door taking off his sunglasses; during pre-testing, a patient discusses her golf game; a patient's case history states he is employed with a construction company. Does your office team recognize these are just a few of the "sun indicators" that provide opportunities to educate patients about eye protection from ultraviolet (UV) rays as well as significantly increase your practice's bottom line?

There is a great deal of potential to increase patient satisfaction through superior service and product knowledge of the amazing sunglass options available today.

This "hot" topic for patient education and product sales is one worth discussing with your front office staff, opticians, assistants, and technicians. By providing training on the basics of sun exposure, how to communicate to patients about the premium performance features of your products and the importance of having a well-planned, pleasing sun wear display, you will set your practice apart from your competition.

Sun exposure basics

UV radation comes from invisible high-energy rays in sunlight. These rays can be absorbed by your eyes and may increase the risk factors for eye diseases. There are three types of UV rays: UVA, UVB, and UVC. The ozone absorbs the UVC rays, thus they are not a risk to our eyesight. Most of the UVB rays are absorbed by the ozone, but still pose some risk for eye damage. They do need to be considered when talking about eye protection from the sun. UVA rays are the most common kind of ultraviolet energy that reaches the earth. UV radiation causes negative reactions in eye tissue and may be linked to cataracts, pterygium, pinguecula, cancer on the eyelids, and macular degeneration.

UVA risk factors associated with unprotected overexposure to UV rays are not limited to natural sunlight, but also can be from artificial indoor rays.

It is recommended to limit outdoor exposure between the hours of 10 a.m. and 2 p.m., and precautions should not be limited only to sunny days. UV rays reach the earth on cloudy or hazy days too.

The UV rays reflect off water, cement, sand, and snow, so don't let the season of the year or location determine your precautions.

Some types of medication may increase the eye's sensitivity to light and may put the patient at an increased risk for sun damage to the eyes. The combination of exposure to light while taking these types of medications appears to be also associated with the risk of developing age-related cataract.

The optometrist should introduce sun exposure educational component during the examination. Paraoptometric staff should re-enforce the information and assist the patient in choosing the right sunwear.

Sunwear recommendations

- Check that sunglasses block 99 percent to 100 percent of UVA and UVB rays
- Choose large lenses that fit close to the eyes and wrap all the way around to the temples to help prevent rays from entering from the sides.
- Determine what types of activities the patient will be doing outdoors. The lens color will affect light and how the patient will see things. Amber tints block blue light and provide greater contrast. They are good to wear for hunting. They may distort vision so they would not be good for driving. Gray tints do not distort vision or alter color, so they are good for driving. They do not provide as much contrast as amber. Brown or green tints are also good for driving. Choose darker and polarized sunglasses for sporting events that take place in bright light with a lot of reflection--such as skiing and fishing. Orange, pink, blue or red-tinted lenses are good for fashion accessorizing. However, these colored lenses are not suitable for driving.

Product knowledge

The more knowledgeable paraoptometric staff is about the functional features of sunwear products, the better they will be able to discuss the products with patients. First, the optometrists will educate the patient about the risk factors associated with overexposure to UV rays. This information will be reenforced by the paraoptometric, and once patients are made aware of the health risks, they will be more willing to consider purchasing sunglasses that offer increased functional benefits.

Paraoptometrics should also be prepared to discuss eyewear protection with young patients or with parents about protecting their child's vision. They should be familiar with the fun shapes and kid-friendly colors, as well as the UV protection and impact resistance features available.

Fashion merges with the sporting lifestyle by providing trendy shapes, hot colors, and sleek metals to create a strong visual identity. Sunglasses are now designed with the hardcore athlete or those with active lifestyles in mind. Find out about the performance features such as polarization, impact protection, rubberized bridges and temple tips to provide your patients with indepth information. Become knowledgeable about current sporting events/personalities and the brands recommended for those particular sports. Discussing topics such as what brand Team USA and the U.S. Olympic Committee selected for their eyewear for the 2012 London Olympic Games, or what brand pro golfer, Fred Couples, hits the links wearing are great conversation starters.

Presentation

Think of how a chef presents his culinary masterpiece to a food critic. A great deal of planning goes into what style and color of plate to use to present the meal, what type of garnish will best complement the presentation, what combination of food colors work best together, and what herbs and spices will bring out the most flavor. This kind of thought in the preparation process should be taken when setting up your display area and determining how brands are to be presented to patients.

A well-planned display area is the key to presenting your product. Keeping the display area clean and dust-free is a must. Every fingerprint and dust particle will be noticed if not taken care of throughout the day. If the signature look of a premium brand also has a fragrance, clothing or accessory line, then use them in the display alongside the sunglasses to connect the two. Keep the display simple so that the focus is on the eyewear. Adding a rock, sculpture, antique toy, a piece of jewelry, or a book will add interest, but will not take away from the overall purpose of the display. Seasonal and holiday displays will draw attention immediately upon entering the office.

Signage at the reception counter informing patient's to feel free to visit the display area will provide opportunities for patients to see what you have to offer, ask questions, and possibly include a pair of sunglasses in their order. Signage within the display area may also draw attention to a particular brand. To provide imagery and identity association with those brands, use verbiage such as:

- Old-world craftsmanship meets modern designs
- For those who appreciate innovative mixes of materials, textures and colors
- Impact protection
- Glare reduction.
- Superior optical quality
- For the active lifestyle

The whole office team should use descriptive language when highlighting the special features of each individual brand. Write descriptive verbiage to be used with each brand. Have staff role-play and practice using the descriptions so they feel comfortable using them with patients.

Use information gathered from the patient during their visit to target particular brands that are best suited for them. If front desk staff learned about a patient's upcoming vacation, they should communicate this information to the optician/ dispenser so they may follow up and direct the patient to brands that are appropriate for their vacation activities.

Limitless potential

Typically, sunwear sales are highest from July to August, followed by May and June. Everyone requires sun protection most every day of the year. When the optometrist and paraoptometric staff work as a team to educate patients about the importance of eye protection, provide excellent customer service, and are knowledgeable of the products, it's an easy decision for the patient to invest in their eye health by ordering protective eyewear, no matter what time of year it is!

VRS to host member forum at Optometry's Meeting®

Plan to join the AOA Vision Rehabilitation Section (VRS) at the Member Forum on Friday, June 29 at Optometry's Meeting®.

The forum is a face-to-face meeting where participants may bring forth issues from their state and share with the group.

The section welcomes state affiliates, AOA members and students to participate.

The issue of health care reform and optometry's professional advancement is one of the topics of discussion. Section members may visit *www.aoa.org/x21318.xml* for more information.

The VRS would like to hear from you concerning new national health care law and visions plans and how that would impact your ability to provide vision rehabilitation care.

You may register online for Optometry's Meeting® at *www.optometrysmeeting.org* using function code 0230.

Please let the VRS Council know your thoughts about health care reform, as well as any other issues or concerns that you have.

SVS program helps members address needs of athletes

The AOA Sports Vision Section (SVS) is pleased to present the Sports Vision University – hosted by seven state affiliates – a four-hour program that consists of two continuing education COPE-approved courses.

"There is a huge market of athletes who have visual needs that could be addressed with sports vision services," said Steven Hitzeman, O.D., one of the course speakers. "These services include protection, correction, contact lenses, altering the visible light transmission to increase contrast of visual stimuli, and enhancing the visual skills that are important for that sport. There is a need for these services, no matter the level of the athlete – professional, college, high school, club sport or recreational activities."

Don't miss out – The program emphasis is on managing the visual performance needs of athletic patients.

Optometrists, students of optometry, residents, opticians, paraoptometrics and athletic coaches and trainers are encouraged to attend.

The upcoming state affiliates hosting this CE program include:

- Montana Optometric Association on May 5. Visit *www.nvo.com/moa* for more information.
- Utah Optometric Association on June 7. Visit *www.utah eyedoc.org* for more information.
- Virginia Optometric Association on June 23. Visit *www.thevoa.org* for more information.

To view the calendar schedule, visit *www.aoa.org/x15029.xml* or contact Section Coordinator Alisa Krewet at *AGKrewet@aoa.org*.

This program is sponsored in part by Vistakon®, a division of Johnson & Johnson Vision Care, Inc.

Most optometrists have limited access to continuing education in sports vision topics. The Sports Vision University curriculum will provide attendees the opportunity to receive a comprehensive overview of the many aspects of sports vision in a four-hour course.

Attention students!

As an active AOSA member, your AOA member benefits are top of the line!

Take advantage of your FREE resourses available with one click of the mouse:
http://www.aoa.org/x4782.xml

- AOA Contact Lens & Cornea Section
- AOA Sports Vision Section
- AOA Vision Rehabilitation Section

Paraoptometric Section seeks community service nominees

The Paraoptometric Section of the AOA is seeking nominations for the 2012 Community Service Award. The award is given to the paraoptometric who demonstrates a commitment to helping improve his or her community and a dedication to the profession of paraoptometry.

The recipient will receive:

- A plaque of recognition
- A $100 personal cash award
- A $100 award to the charity of the recipient's choice

The recipient will receive the award at the Paraoptometric Section Awards Luncheon on June 28, 2012, during the 115th Annual AOA Congress & 42nd Annual AOSA Conference: Optometry's Meeting® in Chicago.

The AOA Paraoptometric Section Awards Luncheon is sponsored by Alcon.

Download a nomination form at *www.aoa.org/Documents/paraoptometric/Community%20Service%20Nomination%20Form%202012.pdf*.

Completed nomination forms should be submitted by March 31 via email with attachments to *PS@aoa.org*.

Paraoptometric Section offers module on optical dispensing

The ABCS of Optical Dispensing Education module available through the AOA Paraoptometric Section that provides staff development. For the order form, visit *https://www.aoa.org/documents/paraoptometric/Transitional_Product_Guide.pdf*.

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Valuation,

from page 32

real property, building and land are excluded from an appraisal and intangibles are valued only if the practice is sold.

The fair market value may be determined by averaging the following three accepted methods of appraisal, weighted to reflect changing and unpredictable trends in managed care and industry economics as they currently exist:

❖ Capitalization of Earnings: Method or Excess Earnings Method – which values goodwill as a multiple of what the practice earned in excess of an economic salary to the owner(s) and of earnings on tangible assets. It attempts to determine the attractiveness of a practice as an investment based upon the owner's effective net earnings, otherwise known as the adjusted earnings of the business enterprise. The final value of the business is based upon the adjusted earnings divided by the "cap rate," which is a percentage basis that evaluates different risk factors involved in investing in an optometric practice versus other investments.

❖ Asset Method – this method values the two primary components that contribute to practice value: tangible and intangible assets. Tangible assets are the physical items of the practice. Intangible assets include goodwill, practice reputation in the community and any other factors that should minimize patient attrition and maximize patient growth during and after the transition.

❖ Comparable Sales Method – this method is most applicable when there are numerous comparable sales, similar to the housing industry. This method takes into account the significant benchmark variables of the practice, for example, the net-to-gross income ratio, percent of income for staff salaries, cost of goods sold, and practice overhead expenses, and then compares these numbers to previous sales of similar practices.

It is important to note the appraised value determined is not necessarily the selling price. There are other factors one should consider. Below are some considerations that may affect a selling price and should be considered.

A. Favorable lease terms and agreement.

B. Seller financing all or part of the sale, with a reasonable down payment.

C. Whether or not some or all of the staff plan to remain through, at least, the transition.

D. The supply and demand of the anticipated time of sale.

E. The "Doing Business As" name and phone numbers remain with the practice.

The second consideration is the economics of the practice which may be equally if not more important in the decision to purchase a practice.

This is the process that will include the gathering of data relevant to the financial stability of the business.

The financial statements provided for the appraisal process contain the necessary information for the economic analysis of the financial integrity of the practice. Important to this analysis is the balance sheet and the income statement.

This process in practice valuation is often referred to as "due diligence."

Projections of income, expenses, potential profit and financing requirements are fundamental considerations in practice acquisitions.

The three primary financial statements, income statement (profit and loss statement), balance sheet and cash flow statement, are all tools with different purposes that may be used to help assess the financial health of the business side of an optometric practice.

The income statement shows how profitable a practice is and is represented in its simplest form by the following formula: Net profit = Revenue – Expenses.

The income statement is perhaps the most informative financial statement.

In this statement, a summary of all revenues and expenses are depicted that occur in a business that will either yield a profit or loss.

This statement is generally divided into the following sections: income, operating expenses, profit or loss and break-even analysis.

The balance sheet provides a glimpse of a practice's financial health at any given point by reporting the cumulative results of all previous decisions that influenced the finances and operations to that time.

The balance sheet shows the assets owed by the practice, the debt obligations owed, and the equity (net worth) the owner has invested in the practice.

The balance sheet is represented by the following formula: Assets = Liabilities (debt) + Owner's equity (net worth).

No other factor affects purchase feasibility more than cash flow after expenses – the net operating income.

The cash-flow statement reveals the sources and uses of practice income for any given period.

It is the definitive account of cash-flow status because it is generated using the cash basis method of accounting.

In this method, income is reported when received and expenses are reported when paid.

In its simplest form, the cash flow (net cash flow) of a business may be calculated by adding the revenue generated from professional fees and optical dispensary sales minus expenses generated from fixed costs (occupancy, general overhead, marketing, payroll, etc.) and variable costs (cost of goods).

The net cash flow of the practice reflects the practice's vitality; a positive cash flow provides for continued growth, whereas a negative cash flow may serve as a precursor to signaling the death of a practice and one that is not attractive for acquisition.

The purchaser of a business is interested acquiring an opportunity for the purpose of securing a positive return on investment, through a recurring stream of positive cash flow.

The return on investment from a positive stream of cash flow should provide the income to support the lifestyle and financial needs of the new owner.

Therefore, the net cash flow should easily account for the fixed and variable costs of the practice and must also generate sufficient revenue to offset the additional expenses arising from the debt load associated with the terms of the loan, the salary (if stipulated in the purchase agreement) for the seller to remain in the practice during the transition period and a salary income for the new owner as well as revenue for long-term financial and estate planning considerations as deemed appropriate by the new owner.

In the final analysis, a practice is only worth what someone is willing to pay for it and is able to afford.

Therefore, both the buyer and seller must weigh practice value relative to lifestyle considerations and how much income is required to satisfy the debt to be retired and the importance of net cash flow of the business in the transaction decision.

No other factor affects purchase feasibility more than cash flow after expenses – the net operating income.

Codeheads,

from page 34

You eventually will be audited, assuming you are contracted with Medicare or other insurers, but if you commit to the caveats above, you will very likely do fine.

Your first answer to an auditor, even without looking at the specific record in question, can and should proudly be, "It will take me a moment to find and review that specific chart, but I can tell you my standard protocol for office visits. First, I carefully interview the patient to learn the reason she/he has come to me. Then I ask as many questions as necessary and possibly review an earlier case history to thoroughly inform myself regarding the needs of the patient. I customize the physical examination, doing only tests I believe will assist me in diagnosing and managing the patient's conditions. Then I record my diagnoses and management options and explain everything to the patient, write orders for myself and my staff for future visits, tests, etc. After all of that is complete, I review the content of the record and choose the ICD and CPT codes that most closely represent what I've done and what I've found and what I plan to do for the patient as a result of my examination. Now, what was your question again?"

Ownership,

from page 37

This type of sale effectively and efficiently transfers all assets and liabilities of the business to the new owner. The titles of all assets belonging to the entity do not need to be transferred, which greatly expedites the sale process.

In addition to reducing the paperwork, this method of sale also preserves the existing contracts the business maintains with other entities. For example, contracts with suppliers, landlords, employees and customers will remain intact. Even line of credit (LOC) agreements with creditors will remain.

In the case of an asset sale, these contracts may have to be renegotiated with the buyer, as the buyer will form a completely new entity. Purchasing stock in an optometric practice is similar to purchasing stock in Google, Apple or any other corporation listed on a major stock exchange. When the stock is purchased, the corporate structure remains intact.

However, a total transfer of assets and liabilities in a stock sale has its drawbacks. The buyer will be responsible even for liabilities that were unknown at the time of the sale, such as product guarantees and employee or customer lawsuits that may not arise for many years after the sale.

In most cases, the buyer has no recourse against the seller to collect payment for these liabilities. A well-drafted purchase agreement can provide some protection to the buyer, but it usually includes a time limit, a "floor" amount (also called a "basket") and a "ceiling" amount. The clause will not be triggered until the undisclosed liabilities, cumulatively, exceed the "basket," and any liability amount in excess of the "ceiling" will be the responsibility of the buyer.

A stock sale is generally advantageous to the seller, with respect to tax liability, in the case of a gain on the sale. Again, it may be helpful to think of the sale of an exchange-listed stock such as Google, where the seller would calculate the gain based on the sales price less the price paid for the stock, also known as the basis, and because the seller's basis in a business may be nominal, most sales result in a capital gain.

The good news is capital gains are taxed at a preferential rate compared to ordinary income. Currently, the capital gain rate is 0 percent to 15 percent, compared to ordinary income rates that range from 10 percent to 35 percent.

While the seller receives fairly favorable treatment in a stock sale, the purchaser ordinarily gets the proverbial short end of the stick. Not only does the purchaser have potential liability as discussed above, but the tax aspects of the purchase are not most favorable. When purchasers buy the stock of a corporation, this becomes their basis in the stock, which is not deductible.

In the Google example, a stockholder only gets to "deduct" the basis in the stock when the stock is sold. This holds true in a practice purchase as well. If a buyer pays $300,000 for the stock of a practice, the buyer gets no tax benefit for this at the time of the purchase; it is simply the buyer's basis in the stock of the practice.

An asset sale occurs when a buyer purchases selected assets from the practice directly. The buyer will use the assets in a new or existing business. The seller will be left with the ownership interest in the business, although it may be worthless.

The tax benefit goes to the buyer in this type of sale structure. Rather than inheriting the existing depreciation schedule from the business, the buyer receives a "stepped up" basis in each of the assets.

The purchase price is allocated to the assets based on their value, and the new basis is then depreciated over the remaining useful life of the assets. The depreciation deduction can be used to reduce the buyer's tax liability for years to come.

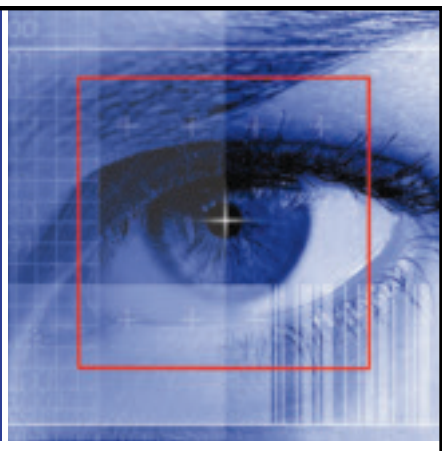
However, the tax benefit for the buyer comes at the expense of the seller. Unlike a stock sale, the gain on the sale could be subject to a higher tax rate due to depreciation recapture.

Because the business has been recognizing depreciation deductions for the assets against ordinary business income, the amount of gain that is attributable to this

See Ownership, page 42

Electronic Health Records for Optometry 2012

Navigating Meaningful Use, Quality Reporting, and e-Prescribing with EHRs



With the American health system rapidly adopting both advanced information technology and pay-for-performance reimbursement systems, the American Optometric Association, in collaboration with State Affiliates, supports practicing optometrists in the implementation and use of Electronic Health Records (EHRs).

Optometrists today must adopt EHRs and related technology, embrace meaningful use and e-prescribing, to be an integral part of the health care system of the future. Taking advantage of Health Information Technology (HIT) incentives and understanding how HIT will ultimately provide the infrastructure for pay-for-performance reimbursement programs in the future will help keep their practice financially viable.

The **AOA's 2012 Electronic Health Records (EHR) Preparedness Program for Optometry** offers practical guidance on EHR implementation through:

- *EHR Software Selection and Implementation*, an entry-level HIT course for optometrists who plan to implement EHR technology in the coming months.
- *EHR Incentive Programs and Meaningful Use Update*, a more advanced course for practitioners who have already implemented EHRs, or will soon, are now preparing to take part in the Medicare or Medicaid EHR incentive program.
- *Physician Quality Reporting System (PQRS) and e-Prescribing Made Easy*, a course explaining PQRS and e-Prescribing and how you can implement these systems in your practice and participate in the Medicare PQRS and e-Prescribing incentive program.

American Optometric Association

The AOA Electronic Health Records Page, a one-stop, online EHR information source for optometrists, on the AOA Website at *www.aoa.org/EHR*.

The AOA Electronic Health Records (EHR) Preparedness Program is generously supported by:

codex techworks · compulink · eyefinity · First Insight · FoxFire · Kowa · MARCO · PracticeDirector · QuikEyes · revolutionEHR

Ownership,

from page 41

depreciation is taxable at the ordinary income tax rate. In addition, if the business being sold is structured as a C-Corporation, the transaction could result in double-taxation. The corporation will be responsible for paying tax on the gain from the sale of assets. The sellers will then have to pay individual income tax to liquidate their investment in the corporation.

An asset sale allows much more flexibility than a stock sale. Instead of purchasing all assets and liabilities, the buyer and seller can pick and choose the assets they want to purchase or sell, respectively. This can also be advantageous to the buyer, who can reduce the total selling price by only purchasing assets that are needed. However, it will greatly increase the amount of time required to negotiate and execute the sale. Usually this increased time investment is worthwhile to the buyer, who will be free of all unknown liabilities incurred by the entity.

For example, let's say Dr. Mullen is ready to retire and his practice consists of one piece of equipment purchased for $75,000, which Dr. Mullen had fully depreciated in the prior year. The fair market value of the piece of equipment is $75,000. Dr. Mullen's practice is a professional limited liability company (PLLC) that has made an S-election. Dr. Mullen started this practice from scratch and has zero basis in his ownership interest in the practice. Dr. Mullen has negotiated a sale to Dr. Miles for $100,000.

If the sale is structured as a stock sale:

- Dr. Mullen will have a $100,000 capital gain, which is the sales price of $100,000 less his basis in the company stock of $0. Dr. Mullen will receive preferential capital gains rates on this sale and will most likely result in $15,000 in federal taxes.
- Dr. Miles will have a $100,000 basis in the company stock and will get no deduction for this amount until he eventually sells the stock to another OD. Dr. Miles has potential liability for any claims against the company. Dr. Miles also will have no depreciation deduction in the future on the piece of equipment, as the company had already fully depreciated it in a prior year. Although Dr. Miles may not have any immediate tax benefits, when he chooses to sell his practice, his will be able to reduce the gain by the $100,000 basis he has in the practice. The first $100,000 of the selling price will not be subject to tax as it is a return of capital.

If the sale is structured as an asset sale - $75,000 for the piece of equipment and $25,000 for goodwill:

- Dr. Mullen will have gain from the sale of the piece of equipment in the amount of $75,000. This is calculated as the fair value of the piece of equipment less the basis, which is zero because he had fully depreciated the asset in a prior year. This is subject to ordinary income tax rates that can range as high as 35 percent. If Dr. Mullen is in the highest bracket, he would owe in excess of $26,000 on this portion of the sale. Dr. Mullen would also have a capital gain of $25,000 for the sale of the patient list, known as goodwill. This would cost Dr. Mullen almost $4,000 in taxes, for a total of near $30,000, or approximately double that of a stock sale.
- Dr. Miles would have a $75,000 basis in the piece of equipment, which he could choose to fully depreciate under code section 179. He would also have a depreciable basis of $25,000 for goodwill that would be depreciable over 15 years. If Dr. Miles is also in the 35 percent tax bracket, the asset purchase will result in almost $27,000 of tax benefits in the first year, for a total tax savings of $35,000 over the next 15 years. If Dr. Miles eventually sold the practice, he will not have any remaining tax benefits. If the sale is structured as a stock sale, Dr. Miles will not have any basis in his practice to offset the income. In addition, if he also structures the sale as an asset sale, any gain may be subject to depreciation recapture.

It is easy to see the tax ramifications are vastly different under each of these scenarios. For this reason, an attorney and a tax adviser should be included in all negotiations, from the early stages to the final signature.

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5010 claims demand new, more specific information

The new Version 5010 claim format is designed to facilitate greater specificity in claim reporting, the AOA Clinical & Practice Advancement Group (AOA-CPAG) noted. All claims for services provided after March 31, 2012, must comply with Version 5010.

Practicing optometrists should contact their billing partners to be sure they will be Version 5010 compliant before the deadline, the AOA-CPAG emphasized. Those billing partners may include claims submission services, electronic health record software developers, and claims clearinghouses.

The 5010 format was primarily developed to accommodate International Classification of Disease, Tenth Edition (ICD-10) codes, which will allow for more detailed reporting of both diagnoses and treatments. However, the new software will go into effect well before ICD-10 implementation and will require health care practitioners and institutions to take a number of additional steps to more specifically identify health conditions and health care services.

The 5010 software format will also require better identification of health care institutions, practitioners, and product suppliers. Optometrists, like other health care practitioners, will have to be vigilant in providing all of the information required under the new 5010 format to avoid claim rejections, AOA-CPAG noted. The AOA-CPAG offers the following tips for successfully filing claims in the 5010 format:

- Billing provider street address – not P.O. boxes – The billing provider address on claims must now be a street address – not a post office box (Practitioners can still use a P.O. box or lock box to receive payments or correspondence from payers as long as they report the box number as a "pay-to" address.)
- Nine-digit ZIP codes – Providers must now submit a full nine-digit ZIP code for billing provider and service facility locations. An easy way to determine the four-digit extension to a standard ZIP code is to look it up on the U.S. Postal Service's ZIP Code Lookup Tool, which can be accessed at *http://ZIP4.usps.com/ZIP4/welcome.jsp*.
- Diagnosis codes on all claims – Diagnosis codes are now required on all claims. The maximum number of diagnosis codes has been increased from eight in Version 4010 to 12 in Version 5010.
- National Provider Identifier (NPI) – Only NPIs can be used as the primary identifier for the billing provider. In the past practitioners have been allowed to report an Employer's Identification Number (Tax ID) or Social Security Number (SSN) as a primary identifier for the billing provider.
- National Drug Codes (NDC) for pharmaceutical injections – Professional claims for injectable medications now must include identifiers such as a NDC, the quantity of the drug administered and the composite unit of measure used. Until now, practitioners have submitted a Healthcare Common Procedure Coding System code as the service-line procedure along with the total charge and units of service. Practitioners can find the 11-digit NDC number printed on the drug package in a 5-4-2 format. The first five digits of the NDC identify the drug manufacturer, the next four identify the specific product and the last two identify the package size. If the segments do not have the appropriate number of digits, practitioners must add zeros at the beginning of the segment.

Practitioners should work with software vendors to ensure all of the information required under the 5010 format is provided in required manner in the fields on claim submissions. They should also consider staff meetings to ensure office personnel are familiar with the 5010 format.

Practitioners should also be aware the transition to the 5010 format is widely expected to result an increase in claim rejections, AOA-CPAG noted.

Practitioners should monitor rejection reports and remittance advice closely over the coming weeks. In the event of 5010-related rejections, practitioners should contact insurance carriers or billing services promptly, AOA-CPAG advised.

For additional information on the new 5010 claim format, see the AOA website ICD-10 page (*www.aoa.org.ICD-10*).

SCO announces $9.4 million building project to add new academic facility to campus

Southern College of Optometry (SCO) announced a $9.4 million building project that will provide its students with new classroom facilities and state-of-the-art instructional space on campus.

The new building in midtown will be the college's most ambitious undertaking since the construction of The Eye Center, the college's public clinical facility, in 2002.

"One of the primary reasons our students choose Southern College of Optometry is the clinical education opportunities at The Eye Center," said Richard W. Phillips, O.D., president of SCO. "We intend to match the caliber of that outstanding clinical facility with a state-of-the-art classroom and instructional teaching building that will meet the educational needs of 21st-century optometry students."

SCO's new building will be located on the expansive concrete patio space behind the college's 11-story tower.

Designed by Memphis-based Formus Inc., the building will provide greater classroom space and flexibility, including enough room to accommodate campus-wide meetings or special events.

An atrium and grand hall will connect the new building to SCO's existing tower, which was completed in 1970.

Laboratory and other teaching spaces will be moved to the tower's first floor, closer to the new building.

These spaces will support the curriculum needs of SCO's four-year academic program.

SCO will break ground May 11, 2012.

The school expects the building to be ready for use in August 2013.

When completed, the building project will add 23,016 square feet to the campus.

To finance the $9.4 million project, SCO has launched a five-year, $4 million capital campaign. An advance phase already has raised $1 million for the project. SCO's board of trustees will finance the remainder of the project through investments and cost-savings measures over the five-year period.

The comprehensive fundraising campaign also aims to improve scholarship opportunities for students and greater vision care access for Mid-South area patients.

Campaign goals include raising $500,000 for student scholarship opportunities and an additional $500,000 to provide more patient care opportunities in the Mid-South, including school and other community-based vision screenings.

"The success of an educational program involves more than just a physical building," Dr. Phillips said. "The college is committed to attracting the best students with this comprehensive campaign, which is designed to improve our academic facilities, scholarship opportunities and patient care access."

AOA order department introduces friends and family referral kits

"Friends & Family Referrals, Visually Simple" is a turn-key solution that promotes "Word of Mouth" practice growth, with canvas artwork kits being offered by the AOA Order Department. Featuring your choice of four customized designs, learn how easy it is to distribute more referral cards with less time. Each branded kit includes: eye-catching 24" x 30" canvas artwork with your logo, 1,000 referral cards with holder and small footprint display easel. With a member price of only $299 (plus shipping and tax where applicable), your practice growth kits will provide an excellent return on investment, by stimulating new referrals on a consistent basis. To professionally build success on success, affordable thank you cards are also available. Stated simply, mailing personalized thank you cards, with more referral cards, is a low-cost and proven practice builder.

Friends & Family designs can be viewed on the AOA's Practice Growth website at *www.aoapracticegrowth.com*.

To order, call the AOA online store at 800-262-2210 or log into *www.aoa.org/onlinestore*.





Abbott Medical Optics

Alcon

Allergan

Bausch + Lomb

CooperVision

Essilor of America

HOYA Vision Care

Johnson & Johnson Vision Care, Inc

Kemin Health

Luxottica Group

Marchon Eyewear

Optos

Shamir

TLC Vision Corporation

Transitions Optical

VisionWeb

Industry Profile is a regular feature in AOA News allowing participants of the Ophthalmic Council ™ to express themselves on issues and products they consider important to the members of the AOA.

Industry Profile: Bausch + Lomb

Bausch + Lomb is one of the best-known and most respected health care companies in the world.

Its core businesses include contact lenses and lens care products, ophthalmic surgical devices and instruments, and ophthalmic pharmaceuticals.

Founded in 1853, the company is headquartered in Rochester, New York.

Its products are available in more than 100 countries.

More information is available at *www.bausch.com*.

We are dedicated to protecting and enhancing the gift of sight – from birth through every phase of life.

It's a mission that can be conveyed in four simple words: "See Better. Live Better."

Visit our Booth #1019 during the American Optometric Association's Optometry's Meeting® to learn more about Bausch + Lomb PureVision2 lenses with High Definition Optics for Astigmatism, which offer "Consistently crisp, clear vision throughout the day" and Biotrue™ multipurpose solution.



Now you can stay at the forefront of lens care by offering your patients an innovative solution that's inspired by the biology of your eyes™.

BAUSCH+LOMB



For more information, visit *www.bausch.com.*

Transitions MAP can help new ODs scout practice locations

By Peter Kehoe, O.D.

Whether you are opening a new practice, moving to a new area or taking a fresh look at your marketing efforts, one of your first steps should be to identify who your current – and potential – patients are in terms of vision needs and behaviors. Once you understand which patient groups are prominent in your area, you can get the most of your outreach efforts by focusing on "high value" patients – or those patients with greatest eye care and eyewear needs.

Recognizing that demographics like ethnicity, age and lifestyle, all influence the amount and type of vision products and services patients need, Transitions Optical has launched a new, interactive Transitions MAP (Market Area Profile) program to assist eye care professionals in the promotion of their practice by identifying the key patient segments in their geographic areas.

Available free of charge through the Transitions Optical trade portal (*http://trade.transitions.com*), the Transitions MAP program provides detailed information about each target audience, and suggests marketing tactics to help reach them. It also offers insight into who might be competing for their business.

New practitioners who are attempting to identify potential practice locations may find the Transitions MAP particularly valuable.

Using it, new practitioners can find areas that may be underserved with respect to eye and vision care, areas in which there may be unmet demand for specific types of eye or vision care, or areas that may offer significant potential for practice growth.

Navigating through the program is simple. Visitors must first enter the ZIP code where their practice is located (or where they would like to locate), which generates an interactive market area map that outlines the geographic vicinity in which most of the practice's current patients and potential new patients likely reside (i.e. the "trade area"). The remainder of the information provided is based on this area; however, ZIP codes outside of it can be viewed if the user wishes to expand their target area.

Users can access detailed descriptions of consumer segments on their market area by target audience, which include information on demographic characteristics. Examples include active seniors and families with children that typically have higher eye care needs.

Recognizing where these target audiences are concentrated within surrounding ZIP codes can help practices to develop communication programs that increase patient loyalty or generate new business by targeting your marketing/advertising to the areas of most impact.

Data can also be obtained on the average amount spent on eyewear by ZIP code. High-value customers residing in these areas represent more revenue potential because they come from households with a large number of family members, who regularly purchase multiple pairs of frames and lenses or who are more likely to consider premium brands of frames and lenses. Practices are more likely to reach these customers if they consider the characteristics and needs of individual target audiences. Finally, information about the competitive landscape of the trade area helps practices to fine tune marketing tactics to stand out from the competition.

(Dr. Kehoe is the Professional Development adviser for Transitions Optical, Inc., and practices in Galesburg, Ill.)

Marco, RevolutionEHR offer first cloud-based EHR, refractive equipment integration

Marco and RevolutionEHR now offer the first cloud-based integration of refractive equipment and EHR software.

The integration leverages the simplicity of the cloud architecture providing RevolutionEHR customers a seamless, single-click solution for automatically populating patient encounters in RevolutionEHR with data collected from their Marco refractive equipment, according to Scott Jens, O.D., chief executive officer of RevolutionEHR.

"We are very excited about our partnership with Marco. Introducing Marco to the cloud is an honor, and our integration will provide a significant efficiency gain for our customers using Marco devices," Dr. Jens said.

As a part of the integration effort, RevolutionEHR has completed the Marco EMR certification process and is now a Marco EMR Certified Partner.

The Marco EMR Certification Program assures doctors and their practices that Marco products will integrate with Marco Certified EMR partners and that they will continue to do so as technology changes. It also eliminates the common question "do you integrate with…?"

Live demonstrations of the Marco equipment – RevolutionEHR software integration will be held at Vision Expo East (Marco booth MS6703 and RevolutionEHR booth MS6616).

RevolutionEHR is the leading provider of cloud-based practice management and electronic health record systems for the optometric community.

RevolutionEHR recognizes optometrists are not in the business of record keeping, accounting, and maintaining complex IT systems.

Rather, they are in the business of patient care. RevolutionEHR's cloud-based architecture provides optometrists the freedom to focus on patient care.

Visit *www.revolutionehr.com* or contact Cindy Braden, RevolutionEHR director of Sales & Marketing, at 877-738-3471, ext. 721.

Marco, The Leader in Vision Diagnostics® offers products that can incorporate EHRs to make practices paperless, thus more efficient and more profitable.

Visit *www.marco.com* or contact Hunter Towns, Marco product manager, at 800-874-5274.

FDA approves preservative-free Merck drug to lower IOP

Merck announced the U.S. Food and Drug Administration (FDA) approved Zioptan™ (tafluprost ophthalmic solution) 0.0015%, the first preservative-free prostaglandin analog ophthalmic solution. Zioptan is approved for reducing elevated intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension.

"Prostaglandin analogs are often used as a first line of treatment to lower intraocular pressure in patients with open-angle glaucoma. The approval of Zioptan will provide a new, effective option to lower IOP," said George L. Spaeth, M.D., Wills Eye Institute, Philadelphia. "I anticipate using Zioptan in many of these patients in my practice."

Zioptan may gradually change eyelashes and vellus hair in the treated eye. These changes include increased length, color, thickness, shape and number of lashes. Eyelash changes are usually reversible upon discontinuation of treatment.

The FDA approval of Zioptan was based on efficacy and safety results from five controlled clinical studies of up to two years in 905 patients. Both preservative-containing and preservative-free formulations of tafluprost were used in these clinical studies.

Zioptan was shown to have powerful IOP-lowering effects. In clinical studies of up to two years in duration, Zioptan, dosed once-daily in the evening, lowered IOP at 3 and 6 months by 6 to 8mmHg and 5 to 8mmHg, respectively, from a baseline pressure of 23 to 26mmHg.

"Zioptan is the first preservative-free prostaglandin analog," said David Michelson, M.D., vice president, Neurology and Ophthalmic Therapeutic Area, Merck Research Laboratories. "We are excited to continue Merck's 50-year tradition of bringing forward additional options to help meet the needs of eye care professionals and their patients."

Merck anticipates that Zioptan will be available to customers this month.

Industry Profile: Kemin

Kemin is a global nutritional ingredient manufacturer and marketer committed to improving the world's nutrition with its products. Kemin is well-known for establishing and building the lutein category for eye health, as well as promoting its FloraGLO® Lutein ingredient brand in both the research community and the nutritional ingredients market.

Kemin is dedicated to help educate consumers about essential eye nutrients, such as lutein and zeaxanthin, that can help maintain healthy vision, increase macular pigment optical density (MPOD), improve visual performance, and help reduce the risk of age-related eye conditions.

Kemin is also committed to increasing awareness regarding the quality of ingredients contained within eye vitamins. Specifically, Kemin teaches eye care professionals why the lutein brand in eye vitamins matter, and why it is important to look for the FloraGLO Lutein brand when recommending lutein-containing supplements to their patients.

FloraGLO is the most clinically researched lutein brand in the world[1] and is being used as the source of lutein for the prestigious second age-related eye disease study (AREDS2)[2]. FloraGLO Lutein is trusted by leading eye vitamin manufacturers worldwide for its quality, established safety profile and documented absorption.

To receive a research binder about macular pigments lutein and zeaxanthin, email us at *floraglo@kemin.com*.



FREE patient education materials

The brochure (at left) explains the benefits of getting 10 mg of lutein daily through diet and/or eye vitamins containing FloraGLO Lutein.

To receive brochures for your practice, visit *www.luteined.org* and sign up today.

[1]*Kemin Foods, L.C. proprietary data based on PubMed search*

[2]*AREDS2 is a human clinical trial conducted by The National Eye Institute, evaluating the effect of lutein supplementation on eye health. Chew, E. (2006). "Age-related eye disease study 2 protocol, National Eye Institute Protocol 07-EI-0025.*

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MEETINGS

March

SOUTH CAROLINA OPTOMETRIC PHYSICIANS ASSOCIATION
SCOPA 2012 SPRING MEETING
March 16-18, 2012
Westin Resort and Spa
Hilton Head Island, SC
Jackie Rivers/Anna Straub
877-799-6721
info@sceyedoctors.com
www.sceyedoctors.com

THE OHIO STATE UNIVERSITY COLLEGE OF OPTOMETRY
BINOCULAR VISION & PEDIATRICS FORUM
March 23, 2012
The Ohio State University
Columbus, OH
Marjean Taylor Kulp, O.D.
614/688-3336
Kulp.6@osu.edu
http://optometry.osu.edu/CE/BVPforum.cfm

IOWA OPTOMETRIC ASSOCIATION
IOWA ANNUAL CONGRESS
March 30-April 1, 2012
Embassy Suites Hotel
Des Moines, IA
515/244-1700
800-Embassy
EmbassySuites.Hilton.com

UAB SCHOOL OF OPTOMETRY
PRIMARY EYE CARE UPDATE
March 30-April 1, 2012
Hill University Center, UAB Campus, Birmingham, AL
Candie Bratton
205/934-5701
cbratton@uab.edu
www.uab.edu/optometry

6TH ANNUAL CONFERENCE ON COMPREHENSIVE EYECARE
March 31-April 1, 2012
Sheraton Hotel, Niagara Falls, NY
www.psseyecare.com

April

SOUTH DAKOTA OPTOMETRIC SOCIETY
SPRING CONVENTION & ANNUAL MEETING
April 12-13, 2012
Cedar Shore Resort, Oacoma, SD
Deb Mortenson, Exec. Dir.
605/224-8199
Deb.mortenson@pie.midco.net
www.sdeyes.org

OKLAHOMA ASSOCIATION OF OPTOMETRIC PHYSICIANS
ANNUAL SPRING CONGRESS
April 13-14, 2012
Embassy Suites and Convention Center, Norman, OK
Heatherlyn Burton
405/524-1075
FAX: 405/524-1077
heatherlyn@oaop.org

NEBRASKA OPTOMETRIC ASSOCIATION
SPRING CONFERENCE
April 13-15, 2012
Embassy Suites Downtown
Omaha, NE
noa@AssocOffice.net
Nebraska.aoa.org

MIAMI NICE SYMPOSIUM CE
MIAMI DADE OPTOMETRIC PHYSICIANS ASSOCIATION
April 14-15, 2012
Westin Colonnade
Coral Gables, FL
Dr. Stephen Morris
305/668-7700
www.MiamiEyes.org
MDOPA.board@gmail.com

4TH ANNUAL SYMPOSIUM ON OCULAR DISEASE
April 14-15, 2012
Crowne Plaza Hotel, Tyson's Corner, VA
www.psseyecare.com

BOARD CERTIFICATION REVIEW COURSE
PARTNERING WITH THE TEXAS OPTOMETRIC ASSOCIATION AND UNIVERSITY OF HOUSTON
April 14-15, 2012
U of H Campus, Houston, TX
http://ce.opt.uh.edu/live-events/OptoBCertification

VISION BY DESIGN 2012
ORTHOKERATOLOGY ACADEMY OF AMERICA
April 19-22, 2012
Scottsdale Resort & Conference Center
Matt Herzberg, Executive Director
866/851-9122
FAX: 630/851-3338
oaaast@gmail.com
www.orthokacademy.com

FLORIDA CHAPTER AAO ANNUAL MEETING
Mission Inn, Howey-In-The-Hills, Florida
April 20-21, 2012
Arthur Young, O.D.
Eyeguy4123@msn.com

WEST FLORIDA OPTOMETRIC ASSOCIATION
BOARD CERTIFICATION PREP COURSE
April 20-22, 2012
Sandestin Hilton Beach Resort
850/279-4361
opttom@hotmail.com
www.wfoameeting.com

SOUTHERN COLLEGE OF OPTOMETRY
SPRING CE 2012
April 20-23, 2012
Southern College of Optometry
Memphis, TN
Dr. Patricia Estes-Walker
901/722-3235
ce@sco.edu
www.sco.edu

NEW MEXICO OPTOMETRIC ASSOCIATION
ANNUAL CONVENTION
April 20-22, 2012
Hard Rock Hotel, Albuquerque, NM
Richard Montoya
575/751-7242
newmexicooptometry@gmail.com

BOARD CERTIFICATION REVIEW COURSE
PARTNERING WITH SALUS UNIVERSITY
April 20-22, 2012
Salus campus, Elkins Park, PA
www.salus.edu/ce/index.html

PINELLAS OPTOMETRIC ASSOCIATION
20TH ANNUAL SUNCOAST SEMINAR
April 21-22, 2012
Hyatt Regency Clearwater Beach Resort & Spa
Clearwater, FL
Dr. Bruce Cochran
Idoc1@aol.com
727/446-8186

Save the date!

Optometry's meeting®

JUNE 27 - JULY 1, 2012
CHICAGO

NJ CHAPTER OF THE AMERICAN ACADEMY OF OPTOMETRY
April 25-29, 2012
Kingston Plantation, Myrtle Beach, SC
Dennis Lyons
732/920-0110
Dhl2020@aol.com

THE ART & SCIENCE OF OPTOMETRIC CARE – A BEHAVIORAL PERSPECTIVE
April 25-29, 2012
Phoenix, AZ
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net
www.oepf.org

2012 ANNUAL SPRING CONVENTION
ARKANSAS OPTOMETRIC ASSOCIATION
April 26-29, 2012
The Peabody, Little Rock, Arkansas
Misty Engler, Membership Director
501/661-7675
FAX: 501/372-0233
misty@arkansasoptometric.org
www.arkansasoptometric.org

KANSAS OPTOMETRIC ASSOCIATION
ANNUAL CONVENTION AND SEMINAR
April 26-28, 2012
Capitol Plaza Hotel, Topeka, KS
785/232-0225
info@kansasoptometric.org

INDIANA OPTOMETRIC ASSOCIATION
115TH ANNUAL CONVENTION
April 27-29, 2012
University Place Hotel and Conference Center
Indianapolis, IN
Bridget Sims
317/237-3560
blsims@ioa.org
www.ioa.org

OEP CLINICAL CURRICULUM FOUNDATION OF VISION THERAPY, PART 1
April 27-29, 2012
Franklin, TN
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net
www.oepf.org

May

MONTANA OPTOMETRIC ASSOCIATION
MOA 2012 ANNUAL EDUCATIONAL CONFERENCE & EXPOSITION
May 2-5, 2012
Red Lion Colonial Hotel, Helena, MT
406/443-1160
sweingartner@rmsmanagement.com
www.mteyes.com

EASTERN STATES OPTOMETRIC CONGRESS
May 5-6, 2012
Crowne Plaza Hotel in White Plains, NY
Stuart Rothman, O.D.
smrod@aol.com

MICHIGAN OPTOMETRIC ASSOCIATION
ANNUAL MEETING & SPRING SEMINAR
May 9-10, 2012
Devos Place/Amway Grand, Grand Rapids, MI
Amy Possavino
517/482-0616
FAX: 517/482-1611
amy@themoa.org
www.themoa.org

PACIFIC UNIVERSITY, COLLEGE OF OPTOMETRY
COEUR D'ALENE CONTINUING EDUCATION
May 11-12, 2012
Coeur d'Alene, ID
Jeanne Oliver
503/352-2740
FAX: 503/352-2929
Jeanne@pacificu.edu
www.pacificu.edu/optometry/ce

CE IN ITALY
May 16-18, 2012
Cinque Terre and the Italian Riviera
James L. Fanelli, O.D.
910/452-7225
jamesfanelli@CEinItaly.com
www.CEinItaly.com

NOVA SOUTHEASTERN UNIVERSITY
ANNUAL MAY EYE CARE CONFERENCE & ALUMNI REUNION
May 18-20, 2012
Fort Lauderdale, FL
954/262-4224

For featured calendar events, email t.peppers@elsevier.com.

To submit standard items for the meetings calendar, send a note to eventcalendar@aoa.org.

Please allow several months' lead time.

oceaa@nova.edu
http://optometry.nova.edu/ce/index.html

CE IN ITALY
May 20-22, 2012
Tuscany Immersion: Castiglion Fiorentino
James L. Fanelli, O.D.
910/452-7225
jamesfanelli@CEinItaly.com
www.CEinItaly.com

June

REGIONAL CLINICAL SEMINAR "MAXIMIZING STEREOPSIS IN PATIENTS WITH STRABISMUS OR AMBLYOPIA"
June 2-3, 2012
Gainesville, VA
Tod Davis, O.D., Diane Serex-Dougan, O.D.
ddavis@verizon.net or dr.diane@verizon.net

OEP CLINICAL CURRICULUM HOSTED BY NOVA SOUTHEASTERN UNIVERSITY COLLEGE OF OPTOMETRY VT/LEARNING RELATED VISUAL PROBLEMS
June 6-10, 2012
Ft. Lauderdale, FL
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

JOINT CONFERENCE ON THEORETICAL AND CLINICAL OPTOMETRY
June 8-10, 2012
Forest Grove, OR
Sally Corngold
smcorngold@oep.org

TROPICAL CE
June 7-17, 2012
Scotland Golf
www.tropicalce.com
sautry@tropicalce.com

VIRGINIA OPTOMETRIC ASSOCIATION
ANNUAL CONVENTION
June 22-24, 2012
Williamsburg Lodge
Williamsburg, VA
Bruce Keeney
804/643-0309
www.thevoa.org

OPTOMETRY'S MEETING
June 27-July 1
Chicago, IL
www.ototmetrysmeeting.org

AOA 2012 ELECTRONIC HEALTH RECORDS PREPAREDNESS PROGRAM FOR OPTOMETRY
June 27, 2012
Optometry's Meeting – Chicago, IL
Register for courses 0875 and 0880
www.optometrysmeeting.org

AOA PRACTICE PATHWAYS – PREPARING FOR YOUR TRANSITION!
June 28, 2012
Optometry's Meeting – Chicago, IL
Register for courses 1043 and 1083
www.optometrysmeeting.org

AOA OPTOMETRY'S CAREER CENTER
June 29, 2012
Optometry's Meeting – Chicago, IL
Register for course 0205
www.optometrysmeeting.org

July

TROPICAL CE
July 1-8, 2012
Bahamas
www.tropicalce.com
sautry@tropicalce.com

Nova Southeastern University Therapeutic Pharmaceutical Agents Certification/Board Review Course
July 8-18, 2012
Fort Lauderdale, FL
954/262-4224
oceaa@nova.edu
http://optometry.nova.edu/ce/index.html

INDIANA OPTOMETRIC ASSOCIATION
SUMMER SEMINAR
July 11, 2012
Ritz Charles Conference Center
Carmel, IN (Indianapolis)
Bridget Sims
317/237-3560
blsims@ioa.org
www.ioa.org

COLORADO VISION SUMMIT
July 12-15, 2012
The Steamboat Grand
Steamboat Springs, CO
1-877-691-2095
cvsummit@visioncare.org
www.visioncare.org

OEP/SCO CONFERENCE CLINICAL VISION CARE (CCVC), SOUTHERN COLLEGE OF OPTOMETRY
July 13-15, 2012
Memphis, TN
OEP or Howard Bacon
949-250-8070
hbbacon@familyoptometry.net

NATIONAL OPTOMETRIC ASSOCIATION
ANNUAL CONVENTION
July 18-22, 2012
Toronto, Canada
877/394-2020
Noa.2020@yahoo.com
www.nationaloptometricassociation.com

PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY
2012 VICTORIA CONFERENCE
July 18-22, 2012
Inn at Laurel Point
Victoria, BC, Canada
Jeanne Oliver
503/352-2740
Jeanne@pacificu.edu
www.pacificu.edu/optometry/ce

OEP CLINICAL CURRICULUM, SOUTHERN COLLEGE OF OPTOMETRY
VT/Visual Dysfunctions
July 19-23, 2012
Memphis, TN
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

Northern Rockies Optometric Conference
July 20-22, 2012
Jackson, Wyoming
Coby Ramsey, O.D.
cramsey@wyoming.com

IOWA OPTOMETRIC ASSOCIATION
IOWA OKOBOJI OPTOMETRIC MEETING
July 20-22, 2012
The Inn
3301 Lake Shore Drive
Okoboji, IA 51355
712/332-2113
877/265-4386
www.theinnatokoboji.com

FOUNDATION OF VISION THERAPY, PART 11
July 27-29, 2012
Franklin, TN
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

August

SOUTHWEST FLORIDA OPTOMETRIC ASSOCIATION EDUCATIONAL RETREAT 2012
August 3-5, 2012
South Seas Island Resort
Sanibel Island, FL
Brad Middaugh, O.D.
239/481-7799
swfoa@att.net
www.swfoa.com

NOVA SOUTHEASTERN UNIVERSITY
SUPER SUNDAY #1
August 19, 2012
Orlando, FL
954/262-4224
oceaa@nova.edu
optometry.nova.edu/ce/index.html

September

Middle Atlantic Optometric Congress
September 6-9, 2012
Doubletree Hotel and Convention Center, Monroeville, PA
Barry Cohen, O.D.
barryc51@gmail.com

OEP CLINICAL CURRICULUM
THE ART & SCIENCE OF OPTOMETRIC CARE-A BEHAVIORAL PERSPECTIVE
September 6-10, 2012
Grand Rapids, MI
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

COLORADO VISION TRAINING CONFERENCE
September 7-9, 2012
Estes Park, CO



Sept. 12-15, 2012
Hilton St. Louis at the Ballpark
St. Louis, MO

info@envisionconference.org
www.envisionconference.org

NOVA SOUTHEASTERN UNIVERSITY
FALL CONFERENCE
September 8-9, 2012
Fort Lauderdale, FL
954/262-4224
oceaa@nova.edu
http://optometry.nova.edu/ce/index.html

NORTHEAST CONGRESS
September 9-10, 2012
Westford, MA
Kathleen Prucnal, O.D.
978/597-5227
drkaprucnal@msn.com

ENVISION CONFERENCE 2012
September 12-15, 2012
Hilton St. Louis at the Ballpark
St. Louis, MO
info@envisionconference.org
www.envisionconference.org

South Dakota Optometric Society Fall Conference
September 13-14, 2012
Hilton Garden Inn, Sioux Falls, SD
Deb Mortenson, Exec. Dir.
605/224-8199
Deb.mortenson@pie.midco.net
www.sdeyes.org

CE IN ITALY
September 14-16, 2012
Florence, Italy
James L. Fanelli, O.D.
910/452-7225
jamesfanelli@CEinItaly.com
www.CEinItaly.com

SOUTHWEST COUNCIL OF OPTOMETRY
SWCO MEETING
September 14-16, 2012
InterContinental Hotel, Addison, TX
Niki Bedell, M.P.H.
713/743-1856
FAX: 713/743-6541
www.swco.org

VERMONT OPTOMETRIC ASSOCIATION
ANNUAL MEETING
September 14-16, 2012
Basin Harbor Club, Vergennes, VT
David J. DiMarco, O.D.
802/524-9561
FAX: 802/524-6060
djd@nveyecare.net

CE IN ITALY
September 18-20, 2012
Tuscany Immersion: Castiglion Fiorentino
James L. Fanelli, O.D.
910/452-7225
jamesfanelli@CEinItaly.com
www.CEinItaly.com

NEBRASKA OPTOMETRIC ASSOCIATION
FALL CONFERENCE
September 21-23, 2012
Younes Conference Center
Kearney, NE
noa@AssocOffice.net
Nebraska.aoa.org

October

Michigan Optometric Association
44th Annual Fall Seminar
October 10-11, 2012
Lansing Center, Lansing, MI
Amy Possavino
517/482-0616
FAX: 517/482-1611
amy@themoa.org
www.themoa.org

VIRGINIA OPTOMETRIC ASSOCIATION
FALL CONFERENCE
October 13-14, 2012
Lansdowne Resort
Leesburg, VA
Bruce Keeney
804/643-0309
www.thevoa.org

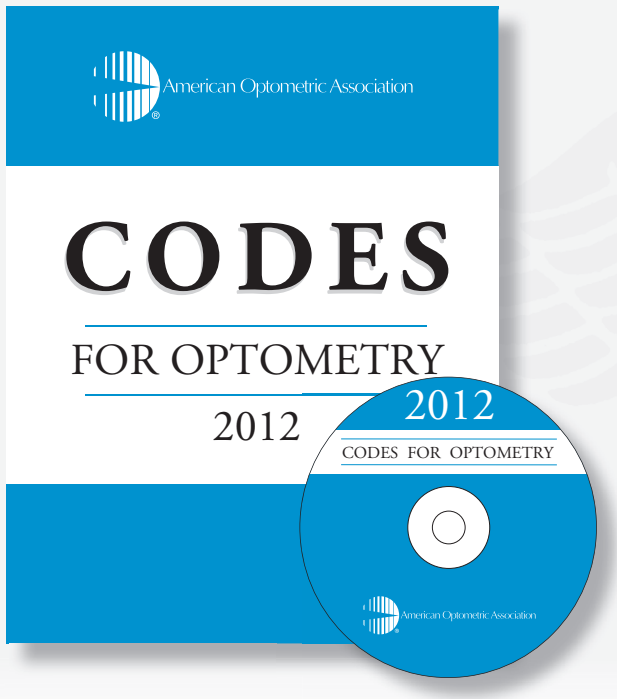
IOWA OPTOMETRIC ASSOCIATION
IOWA HAWKEYE INSTITUTE
October 18-19, 2012
Cedar Rapids Marriott
Cedar Rapids, IA
319/393-6600
800/396-2153
www.marriott.com/hotels/travel/cidmc-cedar-rapids-marriott/
or www.marriott.com

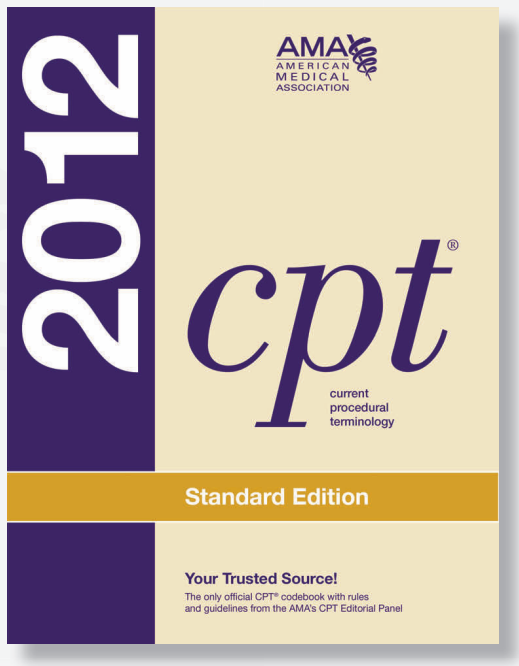
November

OEP CLINICAL CURRICULUM
VT/STRABISMUS & AMBLYOPIA
November 1-4, 2012
Western University College of Optometry, Pomona, CA
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

PACIFIC UNIVERSITY, COLLEGE OF OPTOMETRY CE CHARLESTON
November 9-10, 2012
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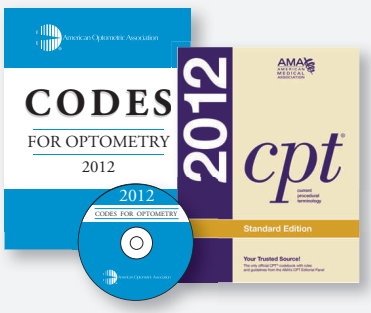
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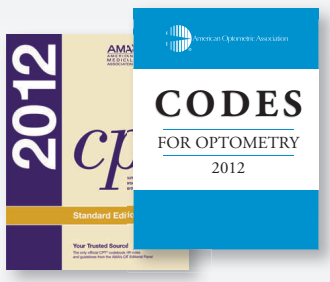
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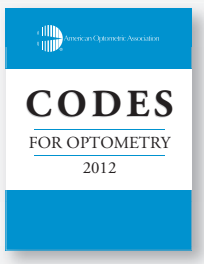
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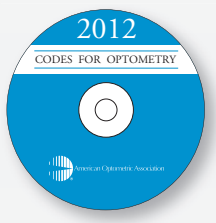
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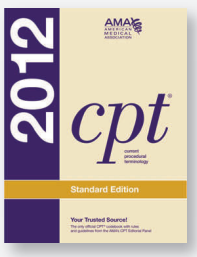
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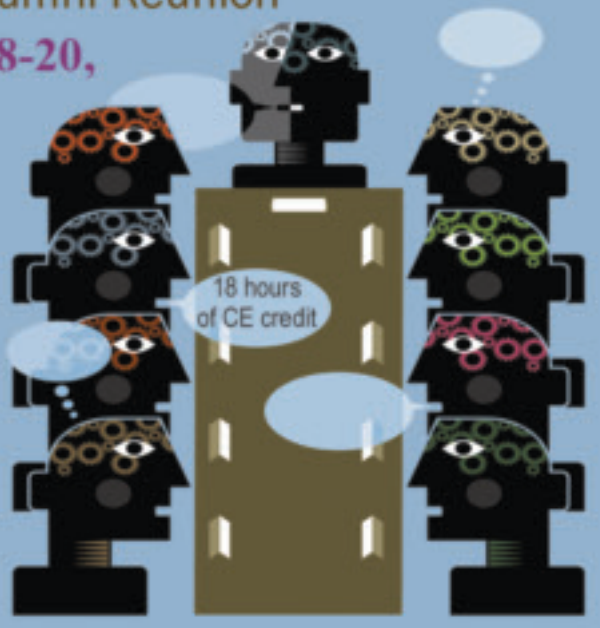
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References: 1. Brobst A, Wang C, Rappon J. Clinical comparison of the visual performance of silicone hydrogel toric lenses with different stabilization systems. *Cont Lens Ant Eye*. 2009;32:243. **2.** In a subject-masked, randomized clinical study at 14 sites with 154 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2008. **3.** In a randomized, subject-masked, multi-site clinical study with over 150 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2005.

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References: 1. Dumbleton K, Woods C, Jones L, et al. Patient and practitioner compliance with silicone hydrogel and daily disposable lens replacement in the United States. Eye & Contact Lens. 2009;35(4):164-171. 2. Yeung K, Forister J, Forister E, et al. Compliance with soft contact lens replacement schedules and associated contact lens-related ocular complications: The UCLA Contact Lens Study. Optometry. 2010;81(11):598-607. 3. Jones L, Dumbleton K, Fonn D, et al. Comfort and compliance with frequent replacement soft contact lenses. Optom Vis Sci. 2002;79:259.

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